



MINNESOTA HEALTH CARE DISPARITIES

BY RACE, HISPANIC ETHNICITY, LANGUAGE AND COUNTRY OF ORIGIN

RESULTS FOR CARE DELIVERED IN 2020

RELEASED MAY 2022

Minnesota Health Care Disparities

By Race, Hispanic Ethnicity, Language and Country of Origin

Results for care delivered in 2020

ABOUT THIS REPORT

As an independent nonprofit dedicated to empowering health care decision makers with meaningful data, MN Community Measurement (MNCM) is a statewide resource for timely, comparable information on health care quality, costs and equity. While Minnesota has some of the best health indicators in the country, there continues to be wide variation in health care quality and wide disparities in outcomes for different population groups. Measurement and data are important tools that call attention to the problem of disparities, motivate efforts to improve, and enable tracking of progress over time.

This report presents information on disparities by race, ethnicity, language, and country of origin (RELC) for quality measures for the 2020 measurement year (data collected in 2021 for care delivered in 2020). This report includes summaries of performance rates for each measure by race/ethnicity, preferred language and country of origin.

For the measures included in this report, MNCM collects patient-level data on RELC to enable these comparisons. The RELC data used in this report only includes data that has been verified by MNCM to have been collected using best practices. More information on best practice methods can be found [here](#). Additionally, a minimum of 30 patients is needed for reporting of the categories presented in the report. Difference from statewide averages are calculated using 95 percent confidence intervals.

ACKNOWLEDGEMENTS

This report is possible by the engagement of several stakeholders who are committed to continuous improvement and recognize the important role measurement plays in helping our community establish priorities and improve together.

MNCM extends our thanks to all medical groups and payers for contributing the data necessary for measurement, to the State of Minnesota for its support through the Statewide Quality Reporting and Measurement System, and to the many members of MNCM committees and workgroups providing ongoing guidance to shape this important work.

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IMPACT OF COVID-19

This report includes statewide data from 2020 and should be used as context for understanding the disruptions experienced in 2020 due to the COVID-19 pandemic. In 2020, MNCM sought input from the community on measurement considerations and made adjustments to the measures to best reflect changes in care delivery. We urge caution in using these data or changes in rates to draw general conclusions about quality of care. In many respects, however, 2020 should be considered a new baseline from which recovery should be measured.

In 2021, MNCM took a closer look at these differences between 2020 and 2019 in a series of spotlight reports/issue briefs. This spotlight report series includes insights from MNCM stakeholders about the factors that contributed to the observed declines in quality measures, including:

SPOTLIGHT REPORTS

- [Summary of Health Care Quality Measures for 2020](#)
- [2020 Results for Claims-Based Quality Measures](#)

ISSUE BRIEFS

- [Optimal Diabetes Care in 2020](#)
- [Optimal Vascular Care in 2020](#)
- [Optimal Asthma Control in 2020](#)
- [Colorectal Cancer Screening in 2020](#)
- [Adolescent Mental Health Screening in 2020](#)
- [Depression Care in 2020](#)

FACTORS INFLUENCING RESULTS OF QUALITY MEASUREMENT FOR 2020

The following is a list of factors specific to COVID-19 that may have influenced quality measures in 2020. These factors are among those listed in response to MNCM consultation with stakeholders about the impact of COVID-19 on measurement. They may have contributed to changes in the number or characteristics of people included in the measures, changes in performance on measures, or both.

• Patient barriers

- Patients' decisions to defer care – out of concern for safety, for financial reasons or because other priorities were important
- Barriers to accessing care via telehealth: familiarity/ease with technology, access to devices and/or broadband, language barriers. On the flip side, telehealth enhanced access to care for some by removing transportation and distance barriers.

• Provider staffing/capacity

- Staff furloughs, burnout, turnover and diversion to higher priority needs.
- Some clinics repurposed/closed.
- Some services restricted or shut down (e.g., colonoscopies, mammograms).
- Shortages of testing supplies and/or lab capacity.

• Care delivery

- Decline in patient visits disrupted clinics' ability to deliver preventive services and manage chronic conditions.
- Transition to telehealth required workflows to be adjusted, including to gather patient-reported outcome (PRO) data used in some quality measures.
- Providers had more difficulty getting patients to complete PRO tools outside of the office setting.
- Care delivered via telehealth was more likely to be missing lab tests/blood pressures.

Minnesota Health Care Disparities

By Race, Hispanic Ethnicity, Language and Country of Origin

Results for care delivered in 2020

KEY FINDINGS

- In general, patients who are Black, Indigenous/Native, Black or are of Hispanic/Latinx ethnicity have significantly lower rates of optimal care compared to the statewide average in most of the reported measures.
 - For all three groups, the largest gaps in performance are in colorectal cancer screening – ranging from 15 to 17 percentage points below the statewide average of 70.6 percent.
- Despite often being among the top five largest groups within the eligible population, Hmong, Somali and Spanish speakers often have significantly lower rates of optimal care compared to the statewide average in most of the reported measures.
 - For all three groups, the largest gaps in performance are in colorectal cancer screening – ranging from 25 to 42 percentage points below the statewide average.
- Similarly, despite often being among the top five largest groups within the eligible population, patients from Mexico, Somalia and Laos often have significantly lower rates of optimal care compared to the statewide average in most of the reported measures.
 - For all three groups, the largest gaps in performance are in colorectal cancer screening – ranging from 29 to 40 percentage points below the statewide average.
 - These groups also have large gaps in performance in follow-up care for depression after 12 months for the adult population compared to the statewide average.

APPENDICES

Appendices to the report present results by medical group and can be found at the following links:

- [Race/Ethnicity](#)
- [Preferred Language](#)
- [Country of Origin](#)

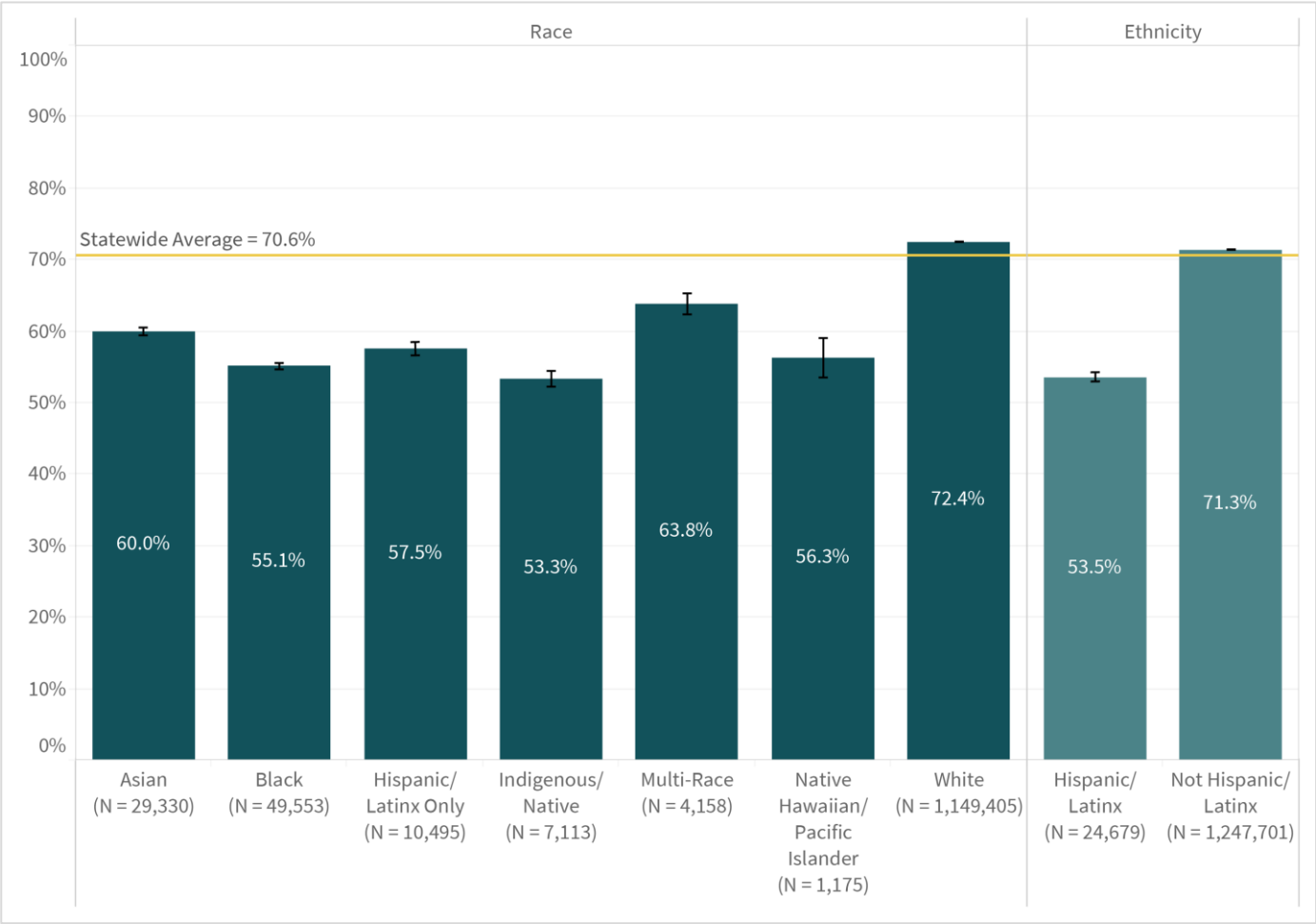
TABLE OF CONTENTS

5	Colorectal Cancer Screening
8	Optimal Asthma Control – Adults
11	Optimal Diabetes Care
14	Optimal Vascular Care
17	Optimal Asthma Control – Children
20	Adolescent Mental Health and/or Depression Screening
23	Adolescent Depression
26	Adult Depression
32	Snapshot Summaries by Race/Ethnicity
38	Statewide Summary by Race/Ethnicity
40	Definitions & Methodology

COLORECTAL CANCER SCREENING

Race/Ethnicity Summary

2020 measurement year



┘ Represents 95% confidence interval

Aside from White patients, patients from all other race categories and patients who are of Hispanic/Latinx ethnicity have significantly lower rates of colorectal cancer screening compared to the statewide average.

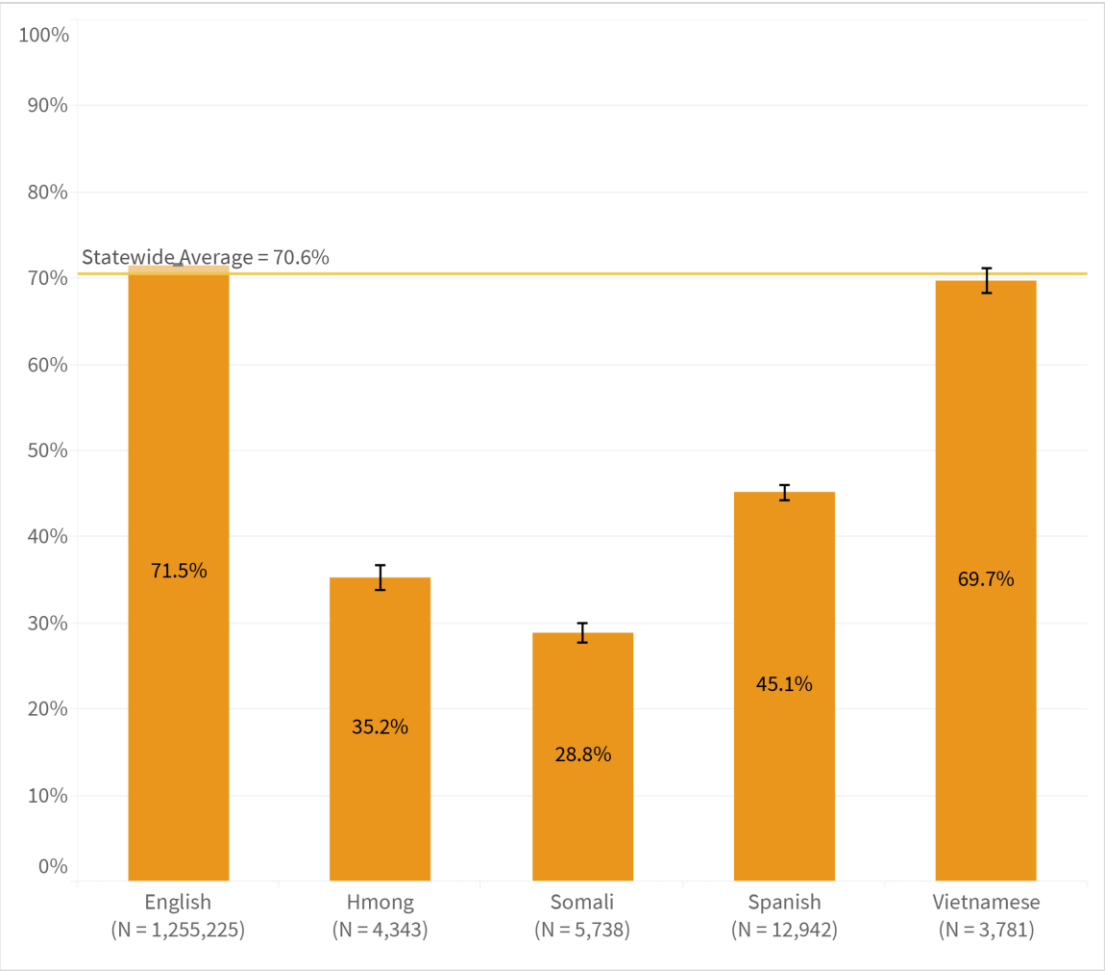
"Hispanic/Latinx Only" race category represents patients who only indicated that they are Hispanic/Latinx and did not provide any other race information.

"Hispanic/Latinx" ethnicity category represents all patients who indicated that they are Hispanic/Latinx, either with or without a separate race category.

COLORECTAL CANCER SCREENING

Preferred Language Summary

2020 measurement year



┆ Represents 95% confidence interval

Patients who prefer to speak English, Hmong, Somali, Spanish or Vietnamese make up 98 percent of the eligible population for the Colorectal Cancer Screening measure.

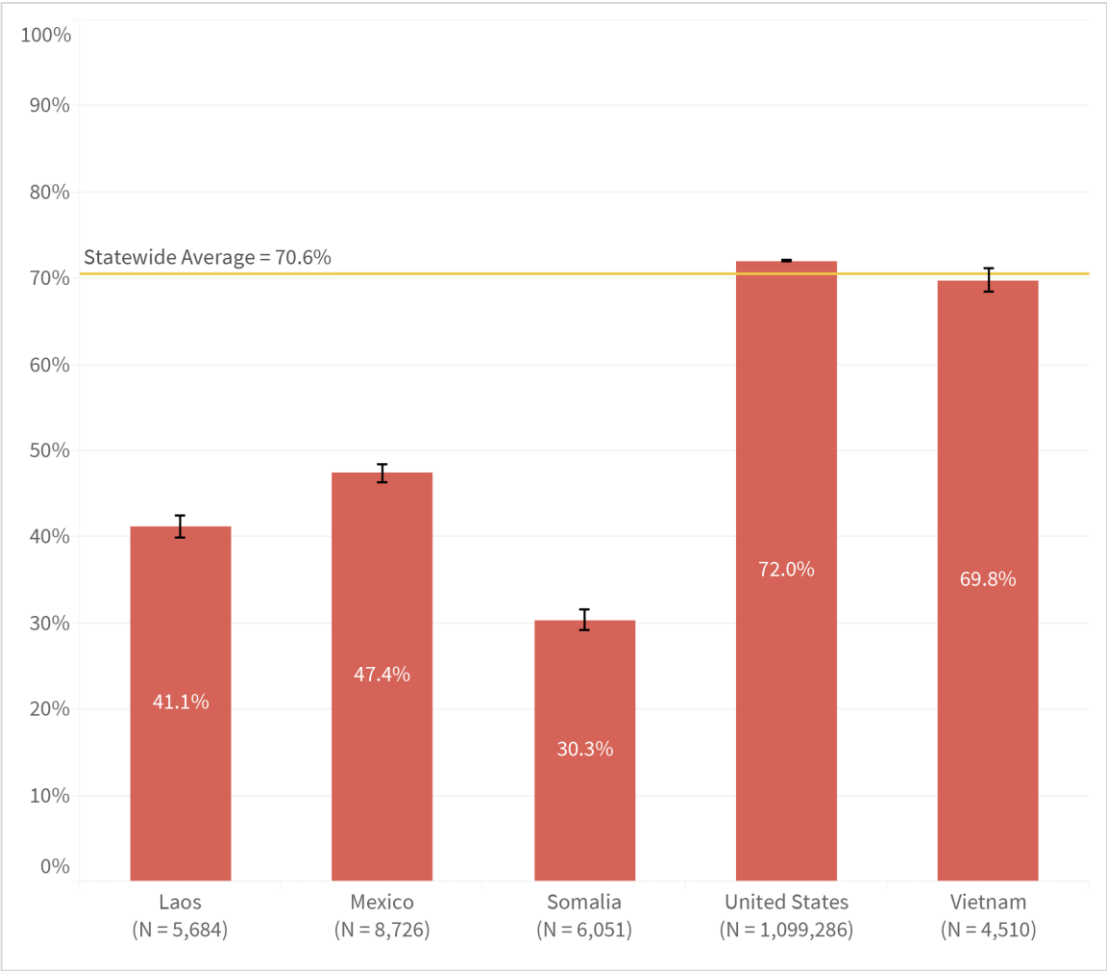
Patients who prefer to speak Hmong, Somali or Spanish have significantly lower rates of colorectal cancer screening compared to the statewide average.

Patients who prefer to speak English have a significantly higher rate of colorectal cancer screening compared to the statewide average.

COLORECTAL CANCER SCREENING

Country of Origin Summary

2020 measurement year



┘ Represents 95% confidence interval

Patients from Laos, Mexico, Somalia, the United States or Vietnam make up 86 percent of the eligible population for the Colorectal Cancer Screening measure.

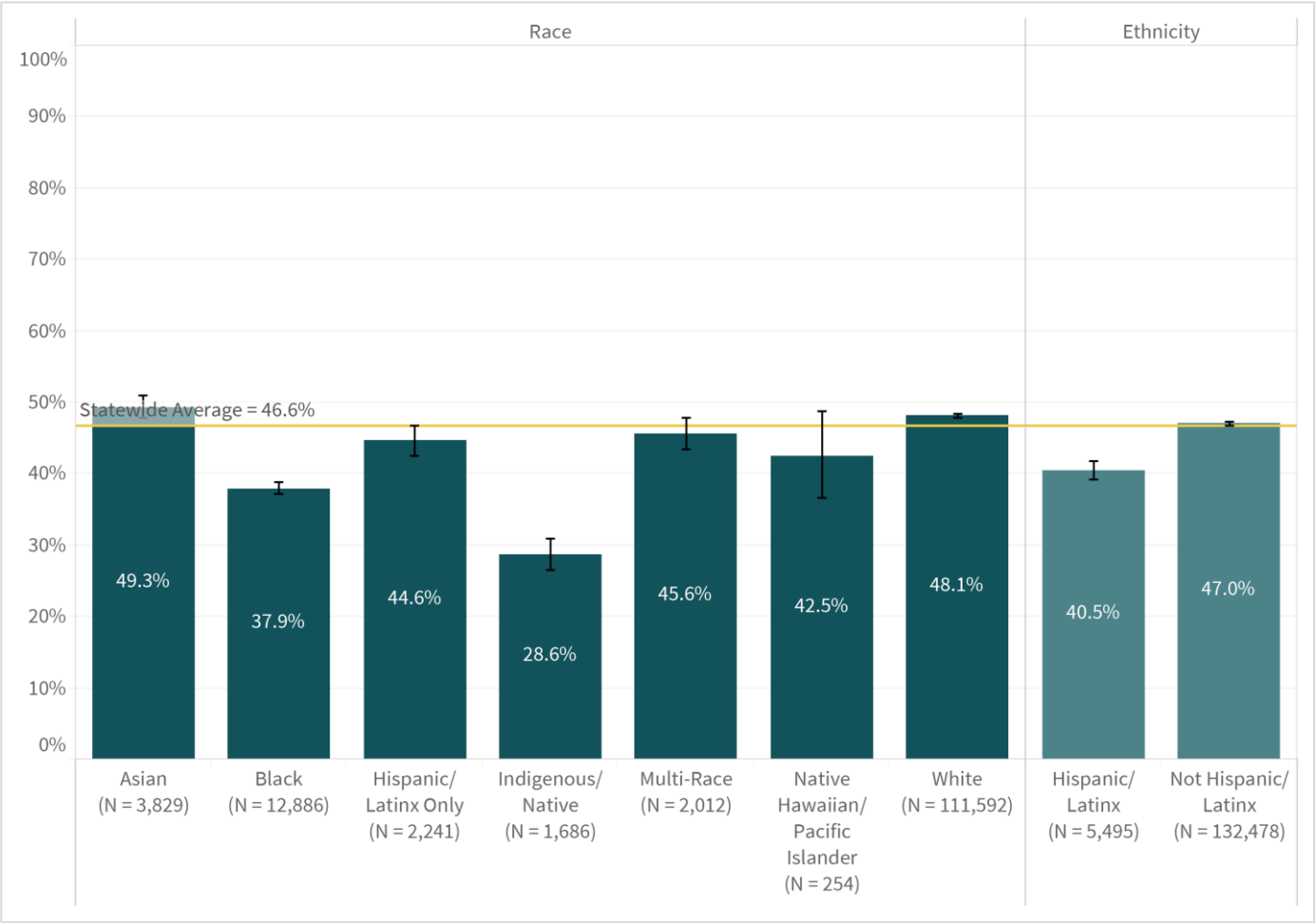
Patients from Laos, Mexico or Somalia have significantly lower rates of colorectal cancer screening compared to the statewide average.

Patients from the United States have significantly higher rates of colorectal cancer screening compared to the statewide average.

OPTIMAL ASTHMA CONTROL - ADULTS

Race/Ethnicity Summary

2020 measurement year



┘ Represents 95% confidence interval

Adult patients who are Asian or White have significantly higher rates of optimal asthma control compared to the statewide average.

Adult patients who are Black, Indigenous/Native or are of Hispanic/Latinx ethnicity have significantly lower rates of optimal asthma control compared to the statewide average.

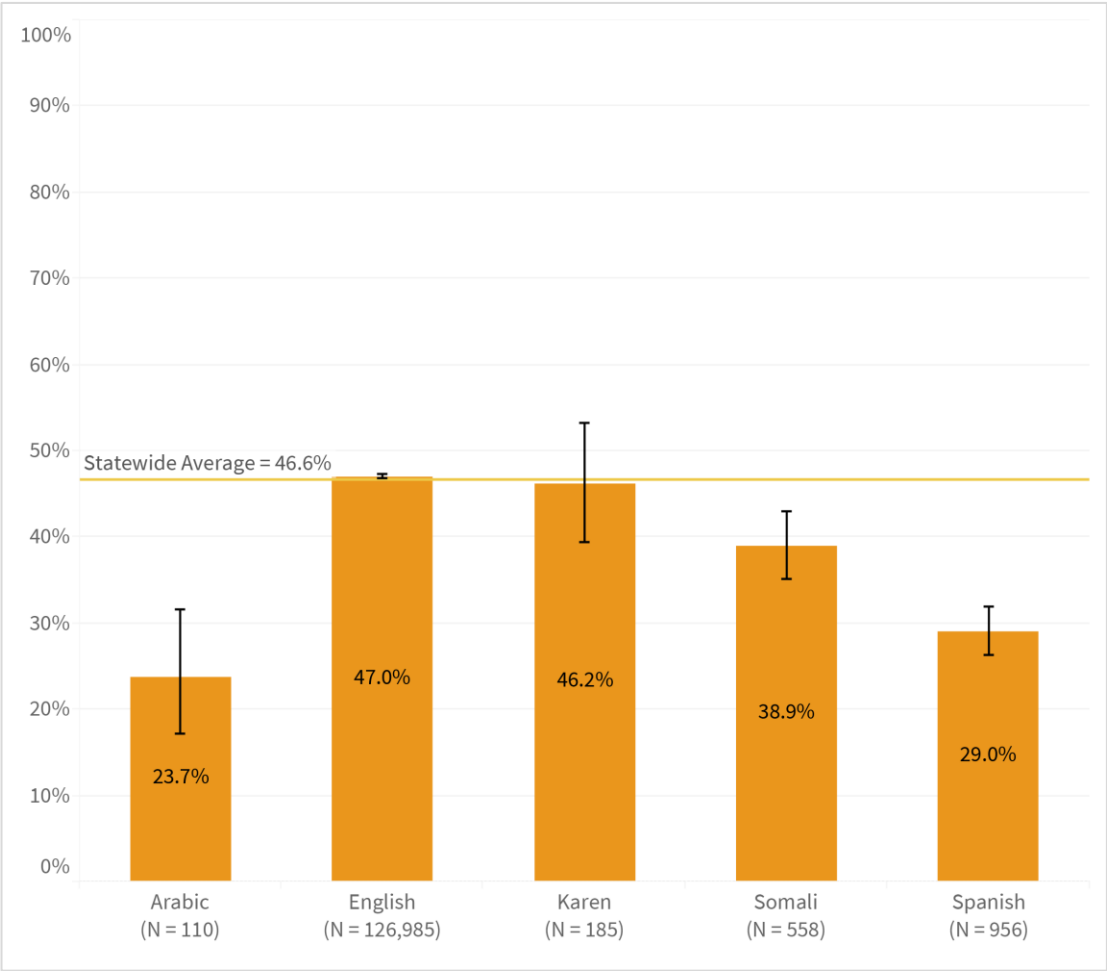
"Hispanic/Latinx Only" race category represents patients who only indicated that they are Hispanic/Latinx and did not provide any other race information.

"Hispanic/Latinx" ethnicity category represents all patients who indicated that they are Hispanic/Latinx, either with or without a separate race category.

OPTIMAL ASTHMA CONTROL - ADULTS

Preferred Language Summary

2020 measurement year



┘ Represents 95% confidence interval

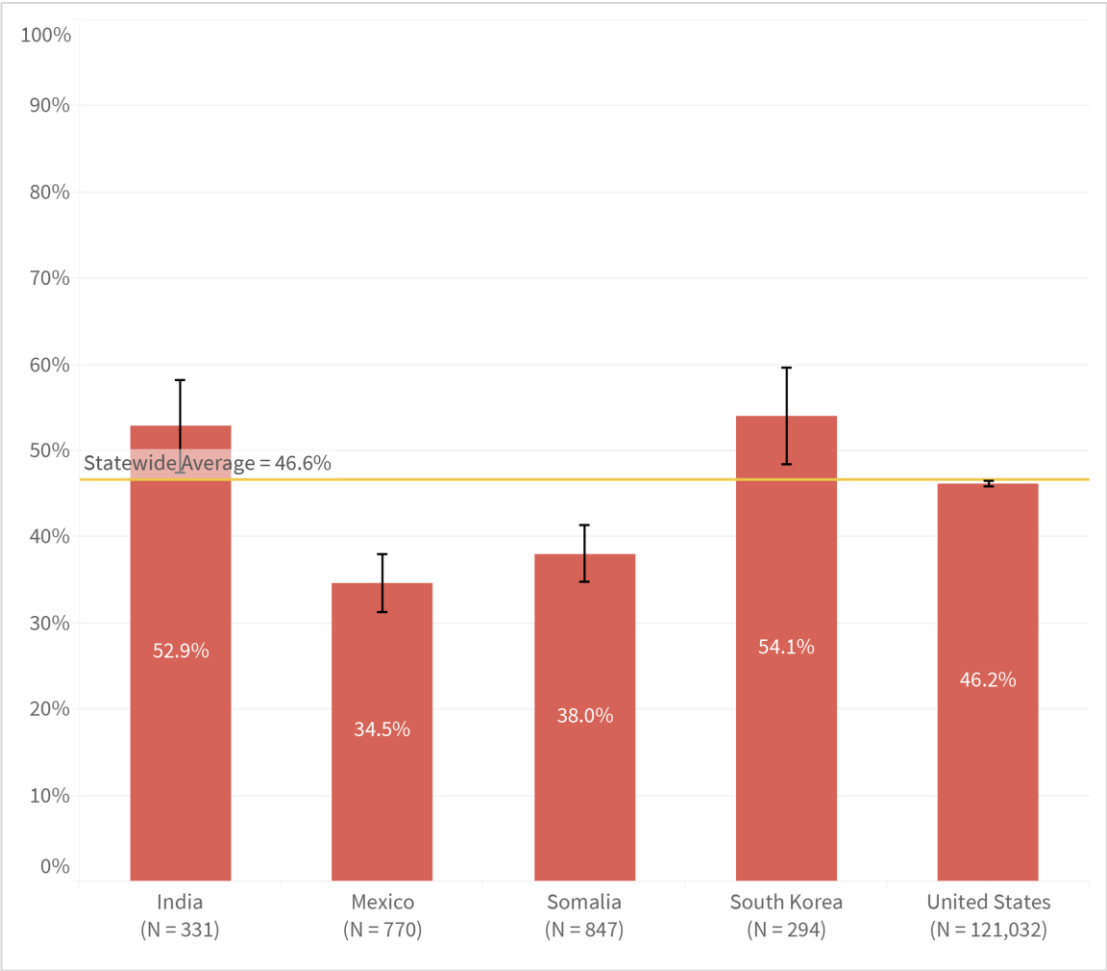
Adult patients who prefer to speak Arabic, English, Karen, Somali or Spanish make up 99 percent of the eligible population for the Optimal Asthma Control measure.

Adult patients who prefer to speak Arabic, Somali or Spanish have significantly lower rates of optimal asthma control compared to the statewide average.

OPTIMAL ASTHMA CONTROL - ADULTS

Country of Origin Summary

2020 measurement year



┃ Represents 95% confidence interval

Adult patients from India, Mexico, Somalia, South Korea or the United States make up 87 percent of the eligible population for the Optimal Asthma Control measure.

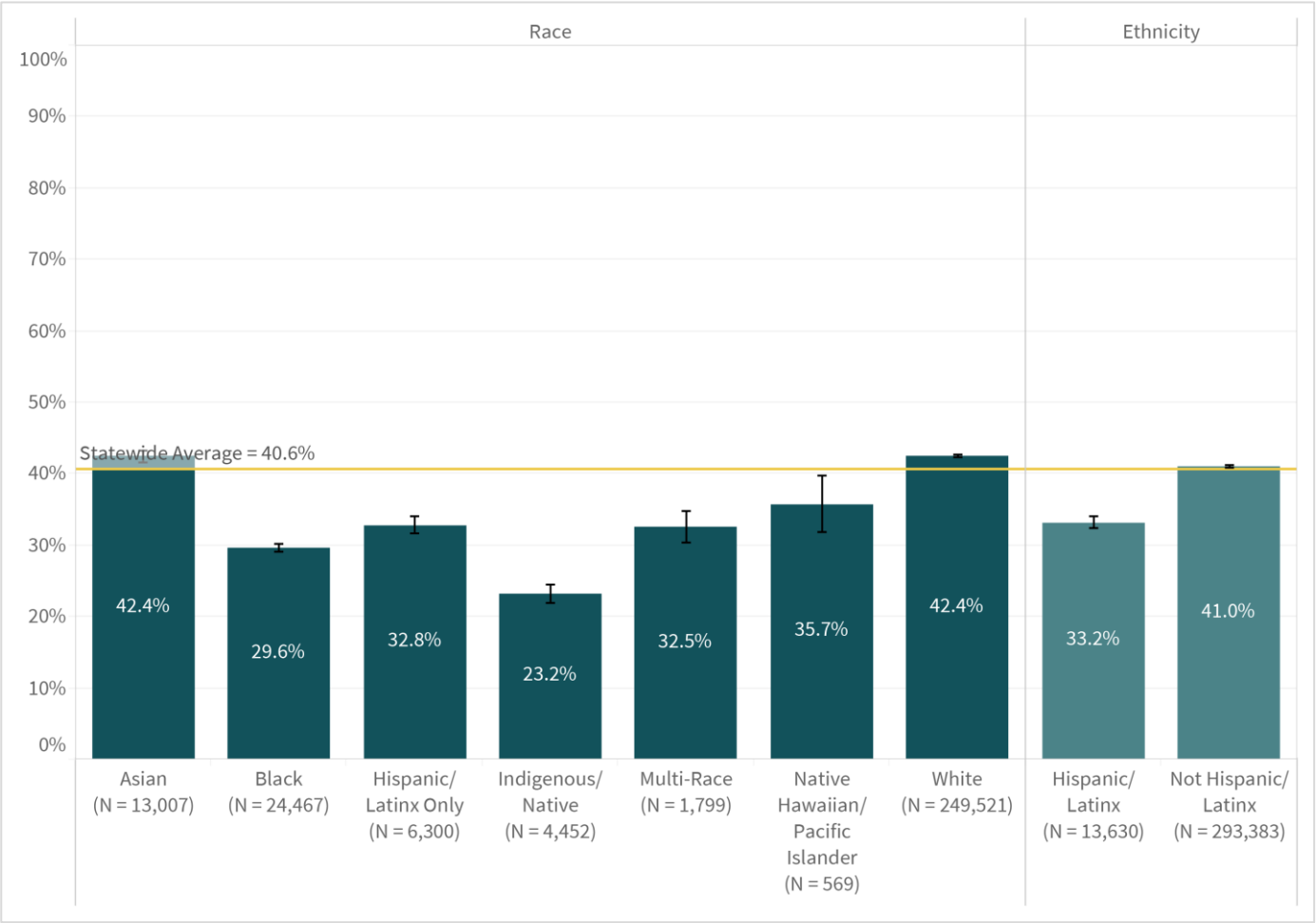
Adult patients from Mexico or Somalia have significantly lower rates of optimal asthma control compared to the statewide average.

Adult patients from India or South Korea have significantly higher rates of optimal asthma control compared to the statewide average.

OPTIMAL DIABETES CARE

Race/Ethnicity Summary

2020 measurement year



I Represents 95% confidence interval

Patients who are Asian or White have significantly higher rates of optimal diabetes care compared to the statewide average, while patients in all other race categories and patients who are of Hispanic/Latinx ethnicity have significantly lower rates.

MNCM has also released a new report that analyzes disparities in much greater detail for the Optimal Diabetes Care and Optimal Vascular Care measures. To view this report, [click here](#).

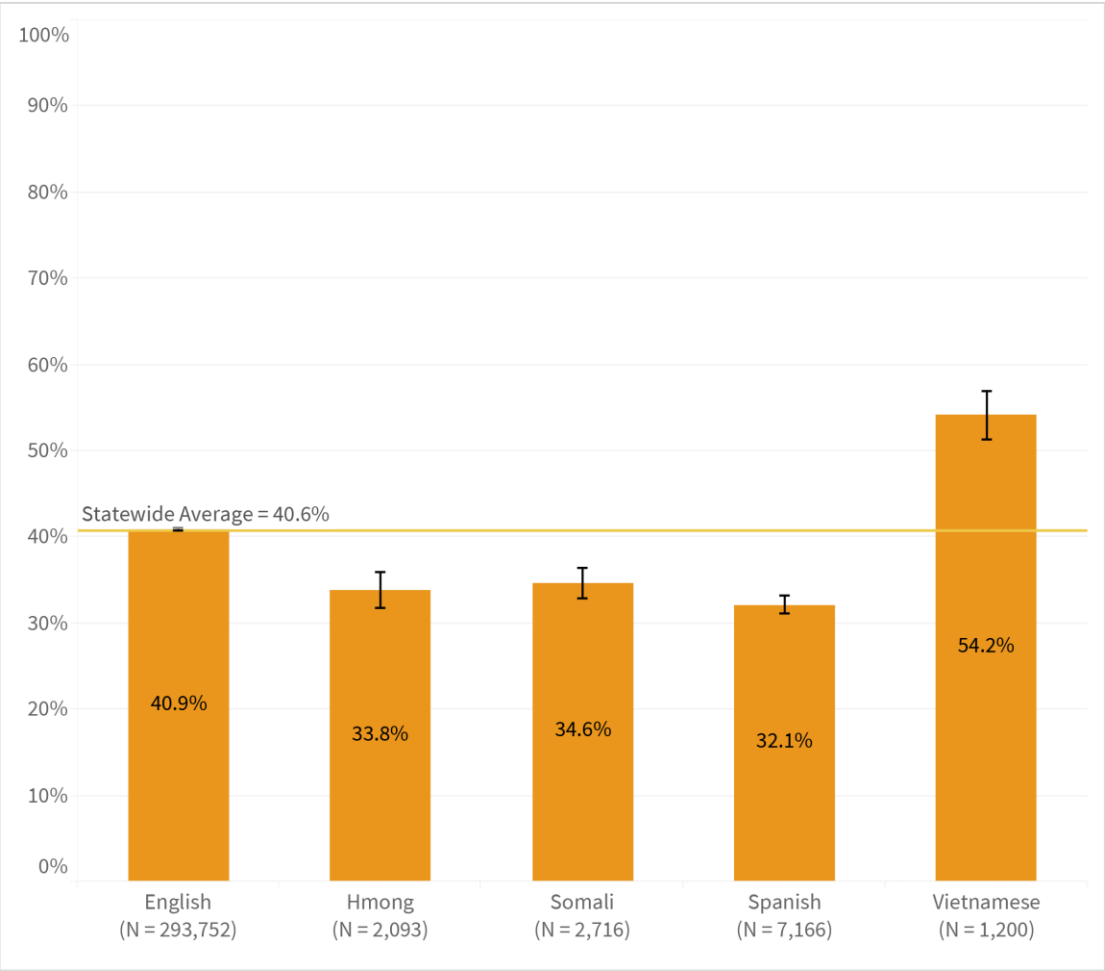
"Hispanic/Latinx Only" race category represents patients who only indicated that they are Hispanic/Latinx and did not provide any other race information.

"Hispanic/Latinx" ethnicity category represents all patients who indicated that they are Hispanic/Latinx, either with or without a separate race category.

OPTIMAL DIABETES CARE

Preferred Language Summary

2020 measurement year



┃ Represents 95% confidence interval

Patients who prefer to speak English, Hmong, Somali, Spanish or Vietnamese make up 98 percent of the eligible population for the Optimal Diabetes Care measure.

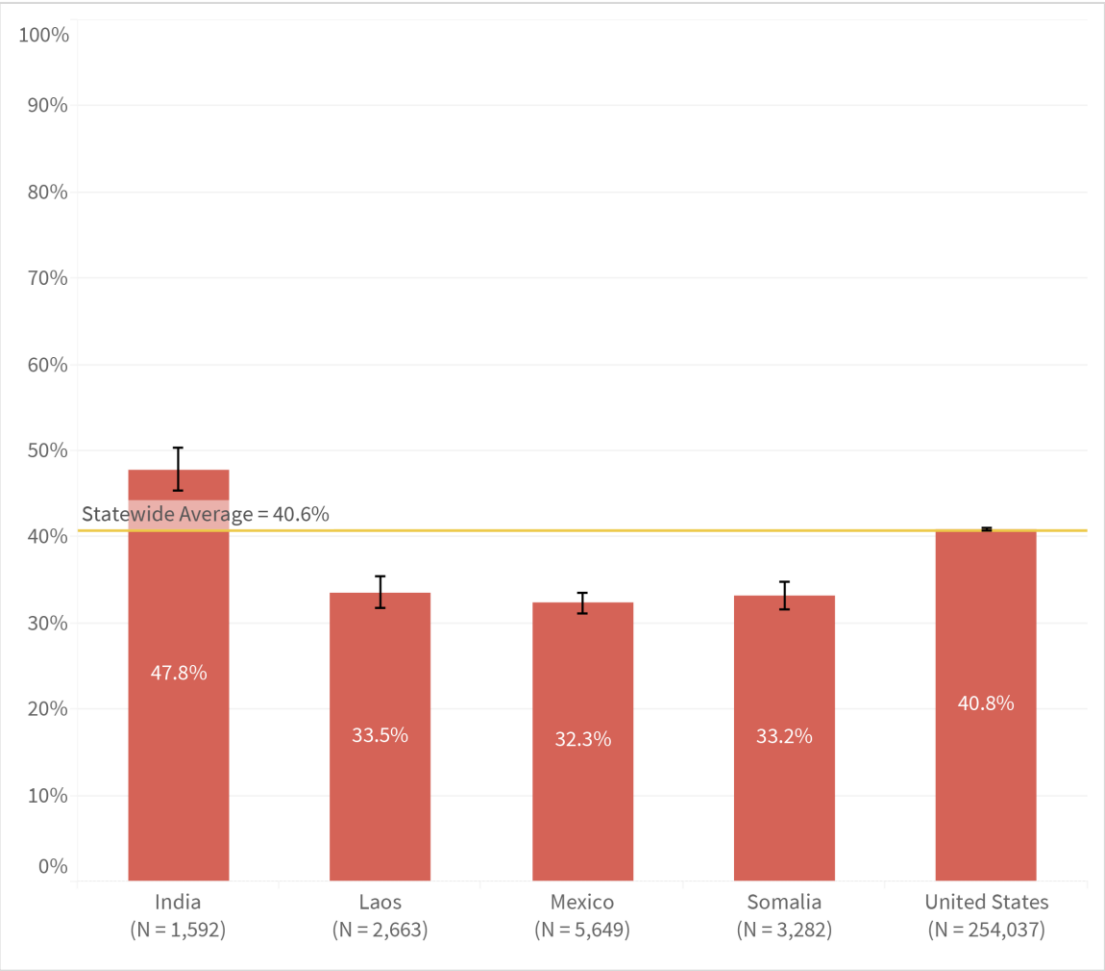
Patients who prefer to speak Hmong, Somali or Spanish have significantly lower rates of optimal diabetes care compared to the statewide average.

Patients who prefer to speak Vietnamese have significantly higher rates of optimal diabetes care compared to the statewide average.

OPTIMAL DIABETES CARE

Country of Origin Summary

2020 measurement year



┃ Represents 95% confidence interval

Patients from India, Laos, Mexico, Somalia or the United States make up approximately 85 percent of the eligible population for the Optimal Diabetes Care measure.

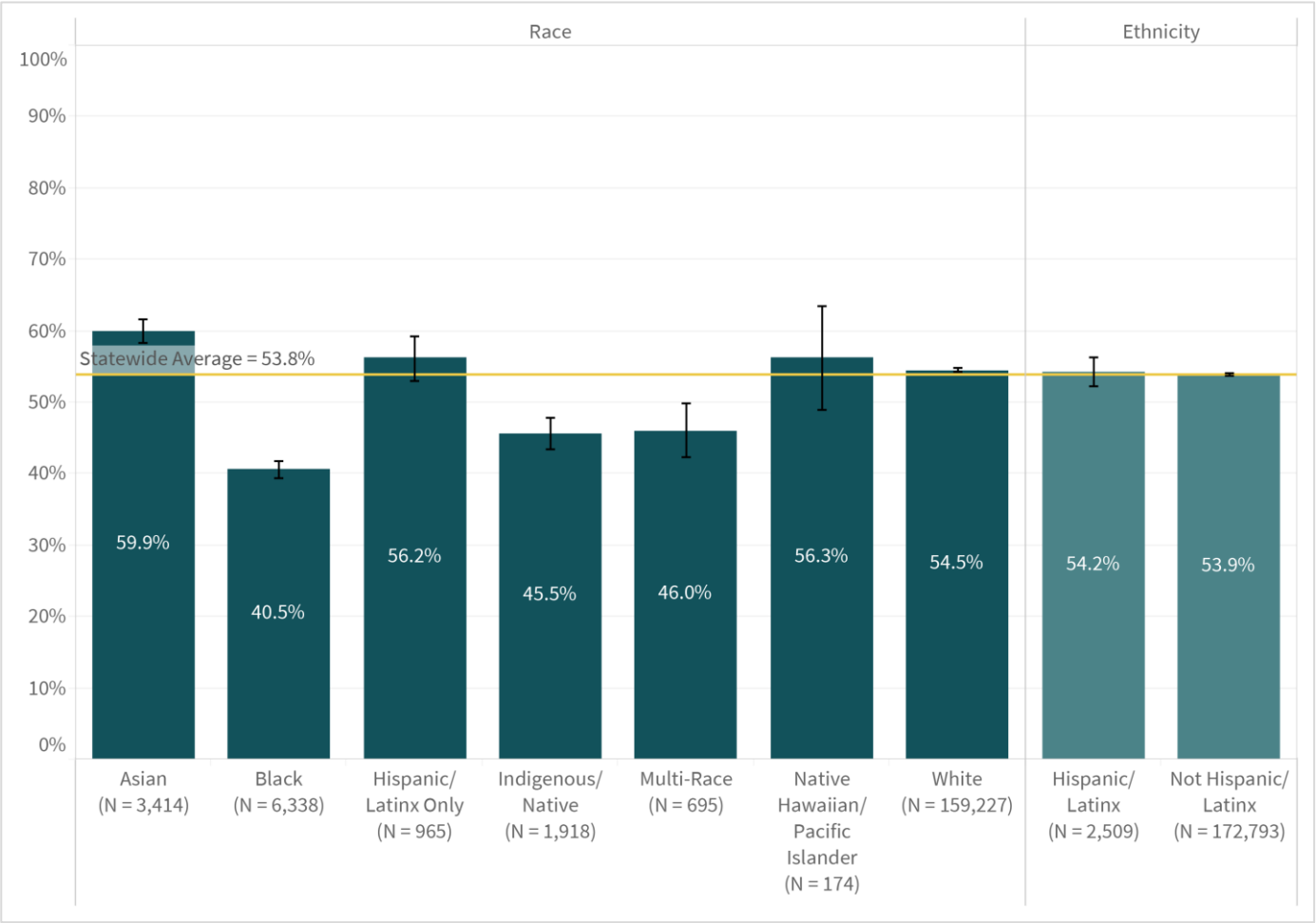
Patients from Laos, Mexico or Somalia have significantly lower rates of optimal diabetes care compared to the statewide average.

Patients from India have significantly higher rates of optimal diabetes care compared to the statewide average.

OPTIMAL VASCULAR CARE

Race/Ethnicity Summary

2020 measurement year



┆ Represents 95% confidence interval

Patients who are Asian or White have significantly higher rates of optimal vascular care compared to the statewide average.

Patients who are Black, Indigenous/Native or Multi-race have significantly lower rates of optimal vascular care compared to the statewide average.

MNCM has also released a new report that analyzes disparities in much greater detail for the Optimal Diabetes Care and Optimal Vascular Care measures. To view this report, [click here](#).

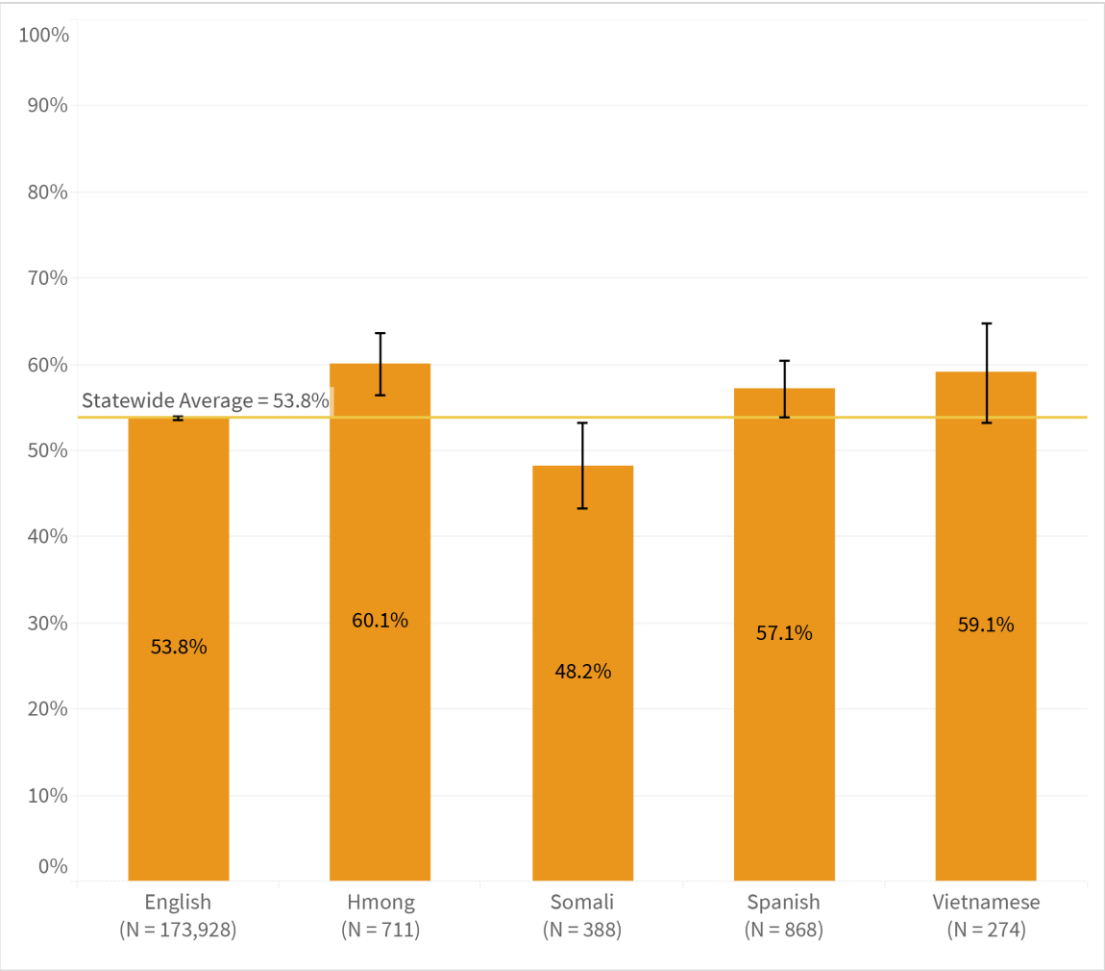
"Hispanic/Latinx Only" race category represents patients who only indicated that they are Hispanic/Latinx and did not provide any other race information.

"Hispanic/Latinx" ethnicity category represents all patients who indicated that they are Hispanic/Latinx, either with or without a separate race category.

OPTIMAL VASCULAR CARE

Preferred Language Summary

2020 measurement year



┃ Represents 95% confidence interval

Patients who prefer to speak English, Hmong, Somali, Spanish or Vietnamese make up 99 percent of the eligible population for the Optimal Vascular Care measure.

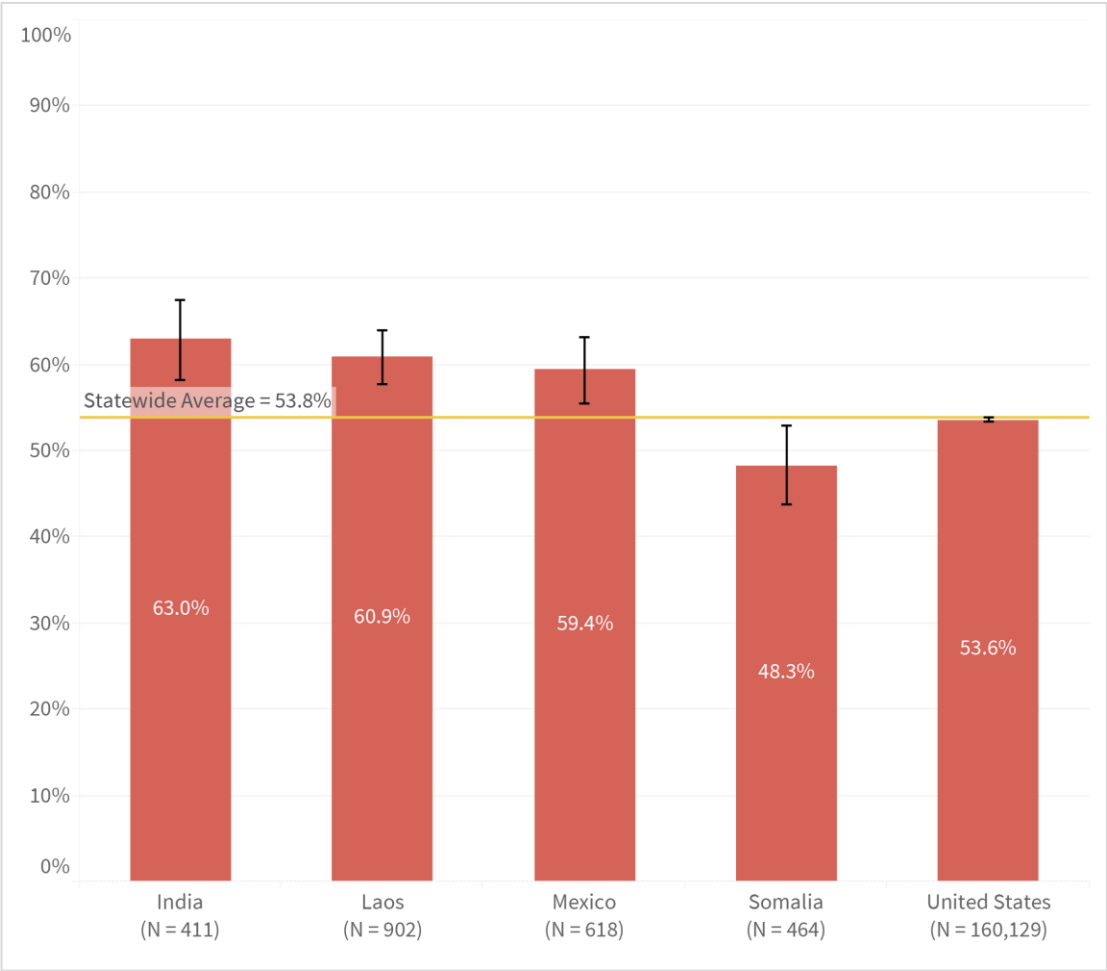
Patients who prefer to speak Somali have significantly lower rates of optimal vascular care compared to the statewide average.

Patients who prefer to speak Hmong have significantly higher rates of optimal vascular care compared to the statewide average.

OPTIMAL VASCULAR CARE

Country of Origin Summary

2020 measurement year



┆ Represents 95% confidence interval

Patients from India, Laos, Mexico, Somalia or the United States make up 91 percent of the eligible population for the Optimal Vascular Care measure.

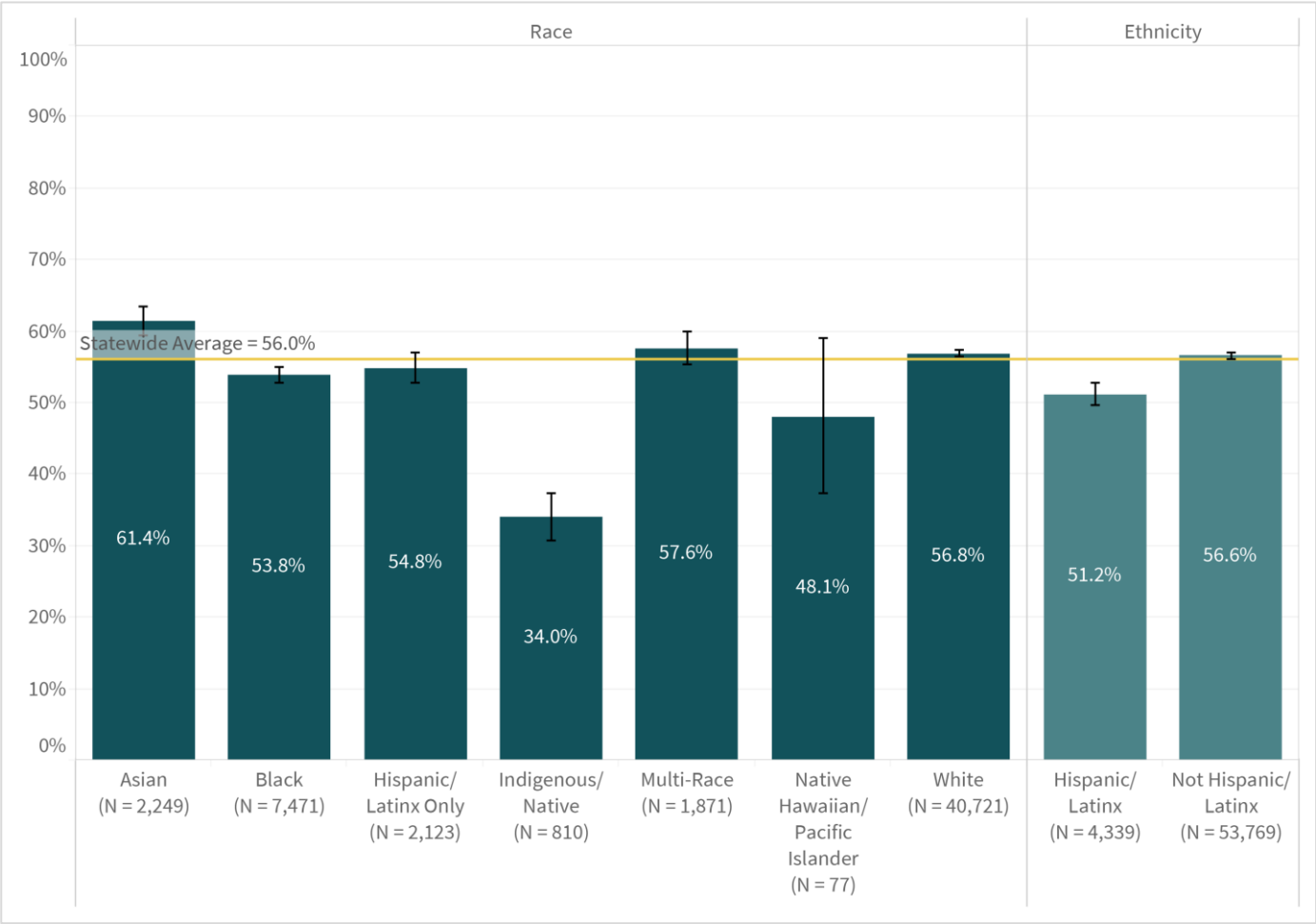
Patients from Somalia have significantly lower rates of optimal vascular care compared to the statewide average.

Patients from India, Laos or Mexico have significantly higher rates of optimal vascular care compared to the statewide average.

OPTIMAL ASTHMA CONTROL - CHILDREN

Race/Ethnicity Summary

2020 measurement year



┆ Represents 95% confidence interval

Children who are Asian have significantly higher rates of optimal asthma control compared to the statewide average.

Children who are Black, Indigenous/Native or are of Hispanic/Latinx ethnicity have significantly lower rates of optimal asthma control compared to the statewide average.

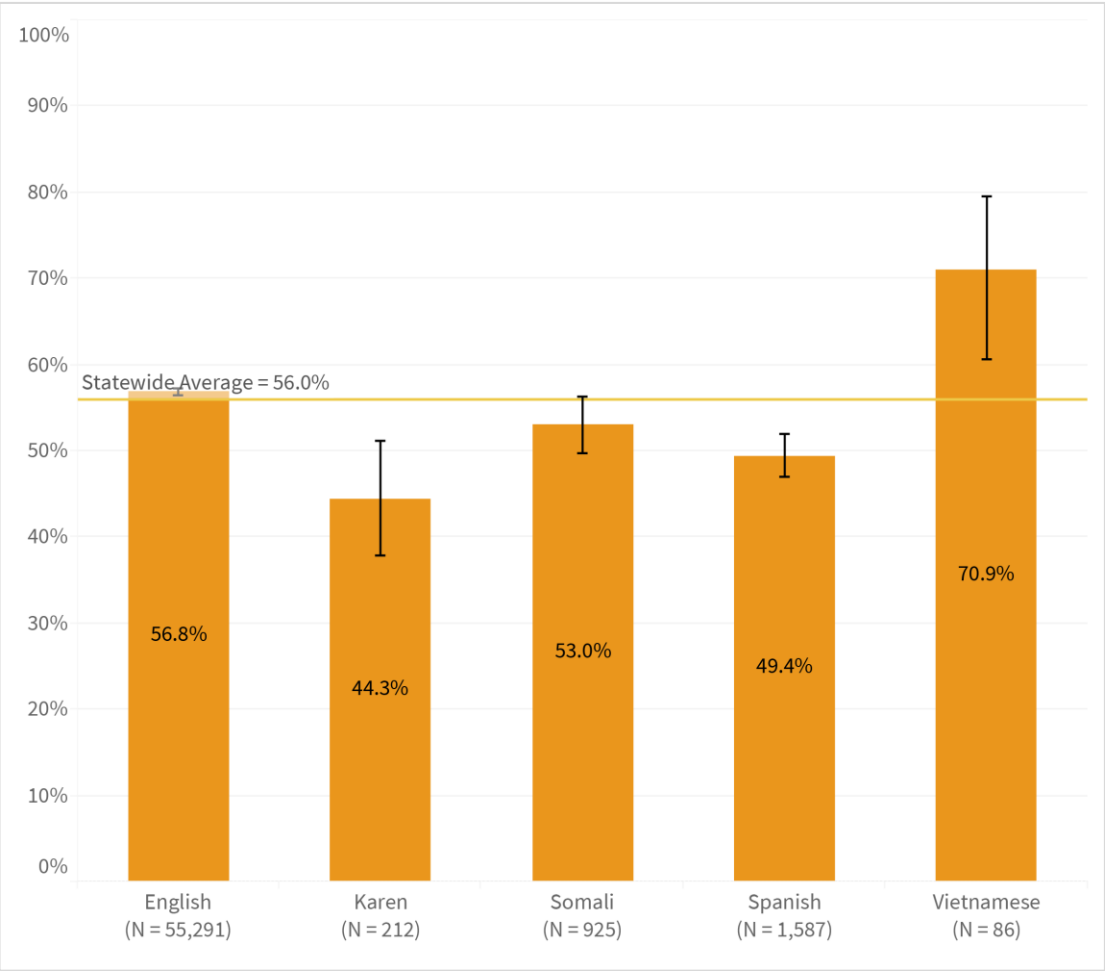
"Hispanic/Latinx Only" race category represents patients who only indicated that they are Hispanic/Latinx and did not provide any other race information.

"Hispanic/Latinx" ethnicity category represents all patients who indicated that they are Hispanic/Latinx, either with or without a separate race category.

OPTIMAL ASTHMA CONTROL - CHILDREN

Preferred Language Summary

2020 measurement year



┆ Represents 95% confidence interval

Children who prefer to speak English, Karen, Somali, Spanish or Vietnamese make up 97 percent of the eligible population for the Optimal Asthma Control measure.

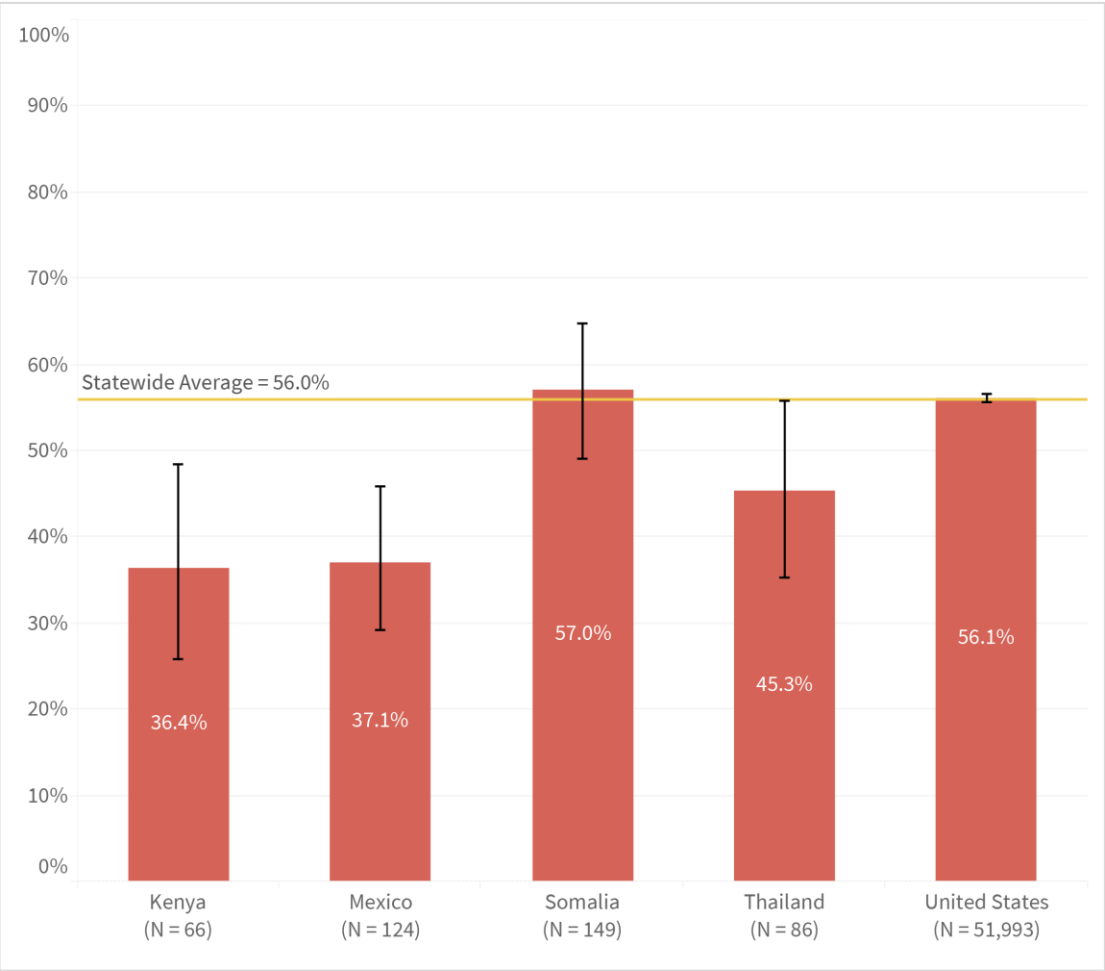
Children who prefer to speak Karen or Spanish have significantly lower rates of optimal asthma control compared to the statewide average.

Children who prefer to speak English or Vietnamese have significantly higher rates of optimal asthma control compared to the statewide average.

OPTIMAL ASTHMA CONTROL - CHILDREN

Country of Origin Summary

2020 measurement year



┆ Represents 95% confidence interval

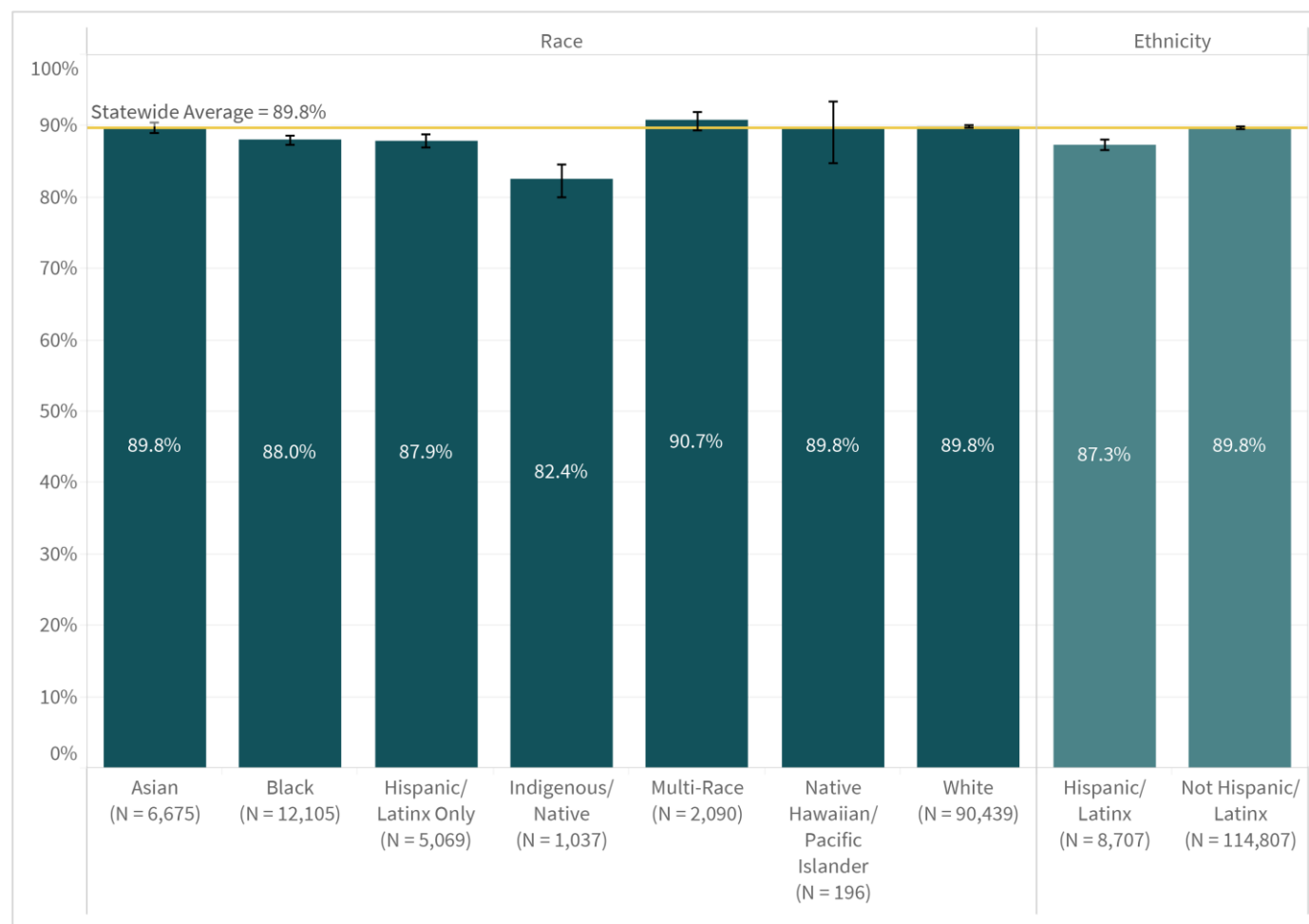
Children from Kenya, Mexico, Somalia, Thailand or the United States make up 88 percent of the eligible population for the Optimal Asthma Control measure.

Children from Kenya or Mexico have significantly lower rates of optimal asthma control compared to the statewide average.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

Race/Ethnicity Summary

2020 measurement year



┌ Represents 95% confidence interval

Patients who are Black, Indigenous/Native or who reported their race as Hispanic/Latinx have significantly lower rates of adolescent mental health screening compared to the statewide average.

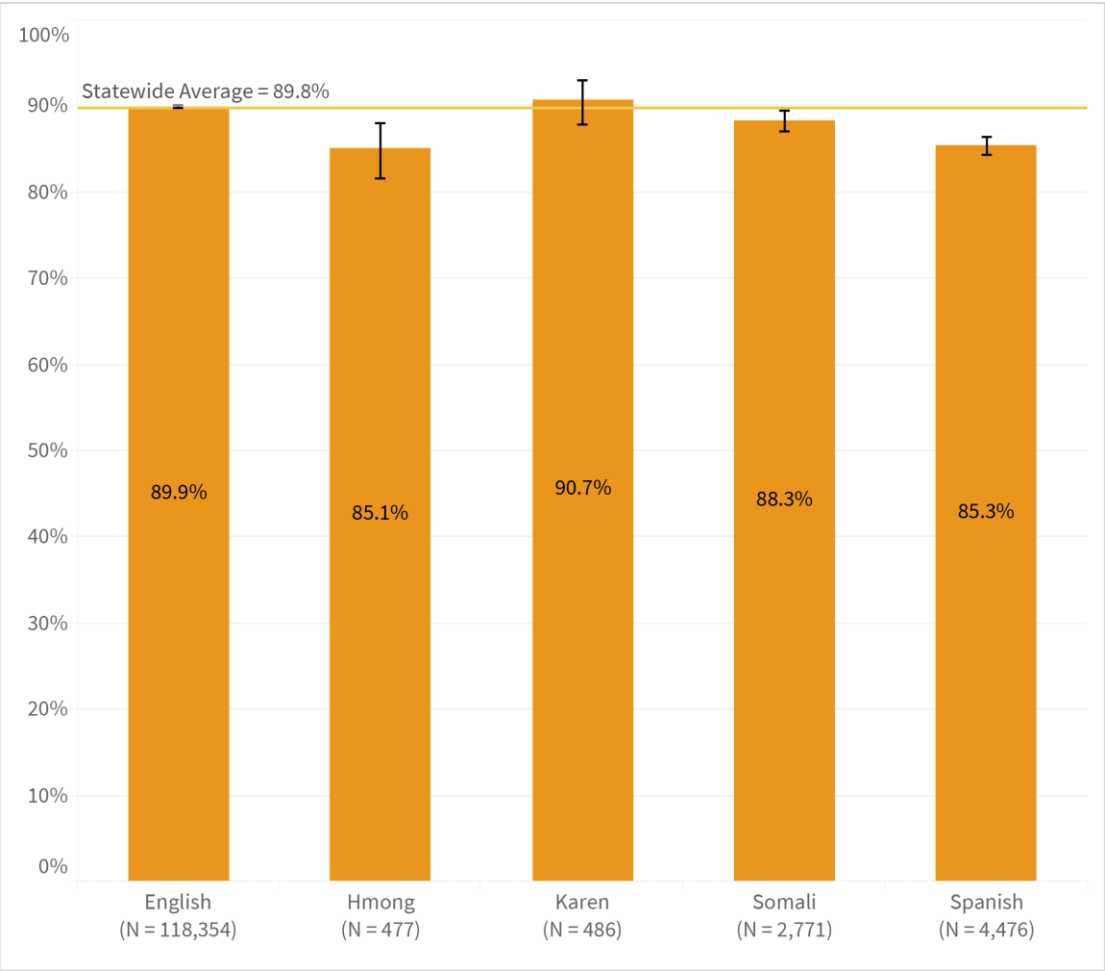
"Hispanic/Latinx Only" race category represents patients who only indicated that they are Hispanic/Latinx and did not provide any other race information.

"Hispanic/Latinx" ethnicity category represents all patients who indicated that they are Hispanic/Latinx, either with or without a separate race category.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

Preferred Language Summary

2020 measurement year



┃ Represents 95% confidence interval

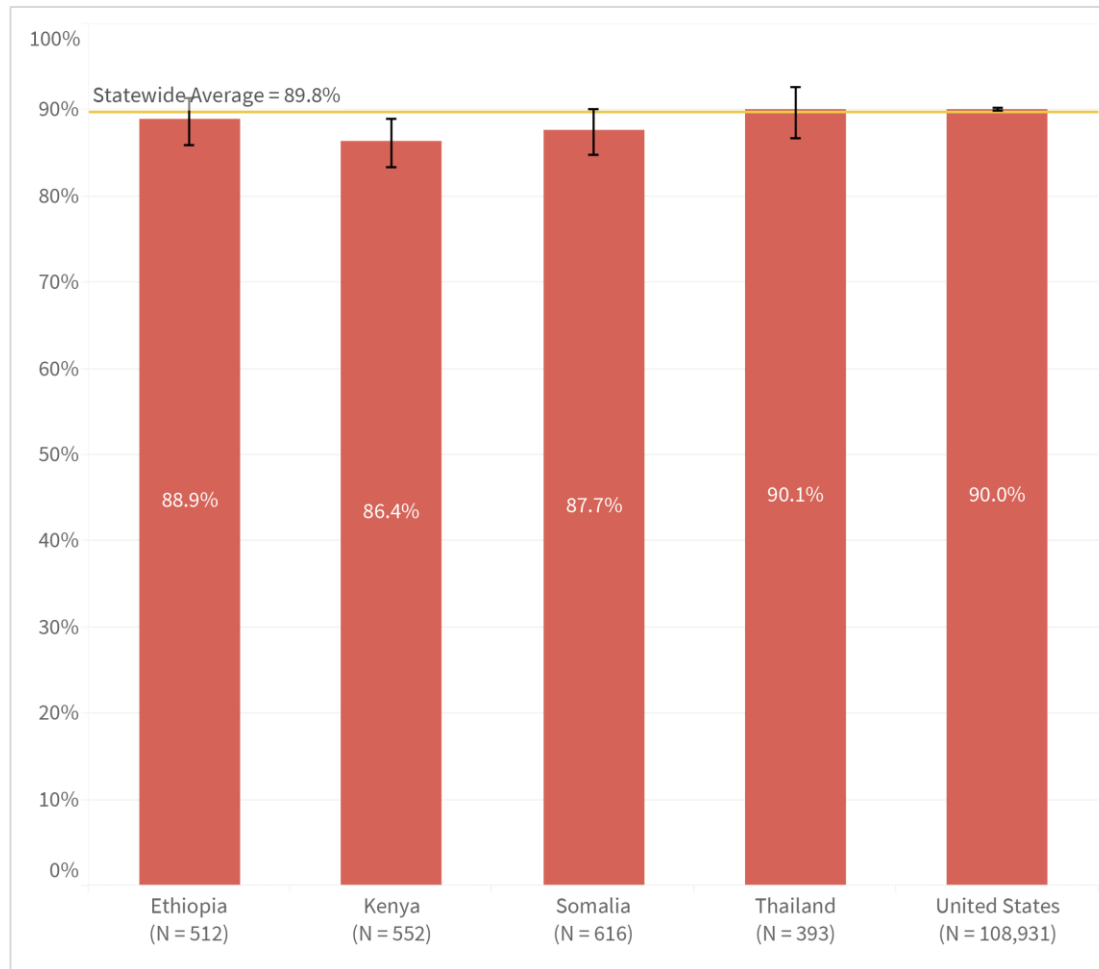
Patients who prefer to speak English, Hmong, Karen, Somali or Spanish make up 96 percent of the eligible population for the Adolescent Mental Health and/or Depression Screening measure.

Patients who prefer to speak Hmong or Spanish have significantly lower rates of adolescent mental health screening compared to the statewide average.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

Country of Origin Summary

2020 measurement year



┌ Represents 95% confidence interval

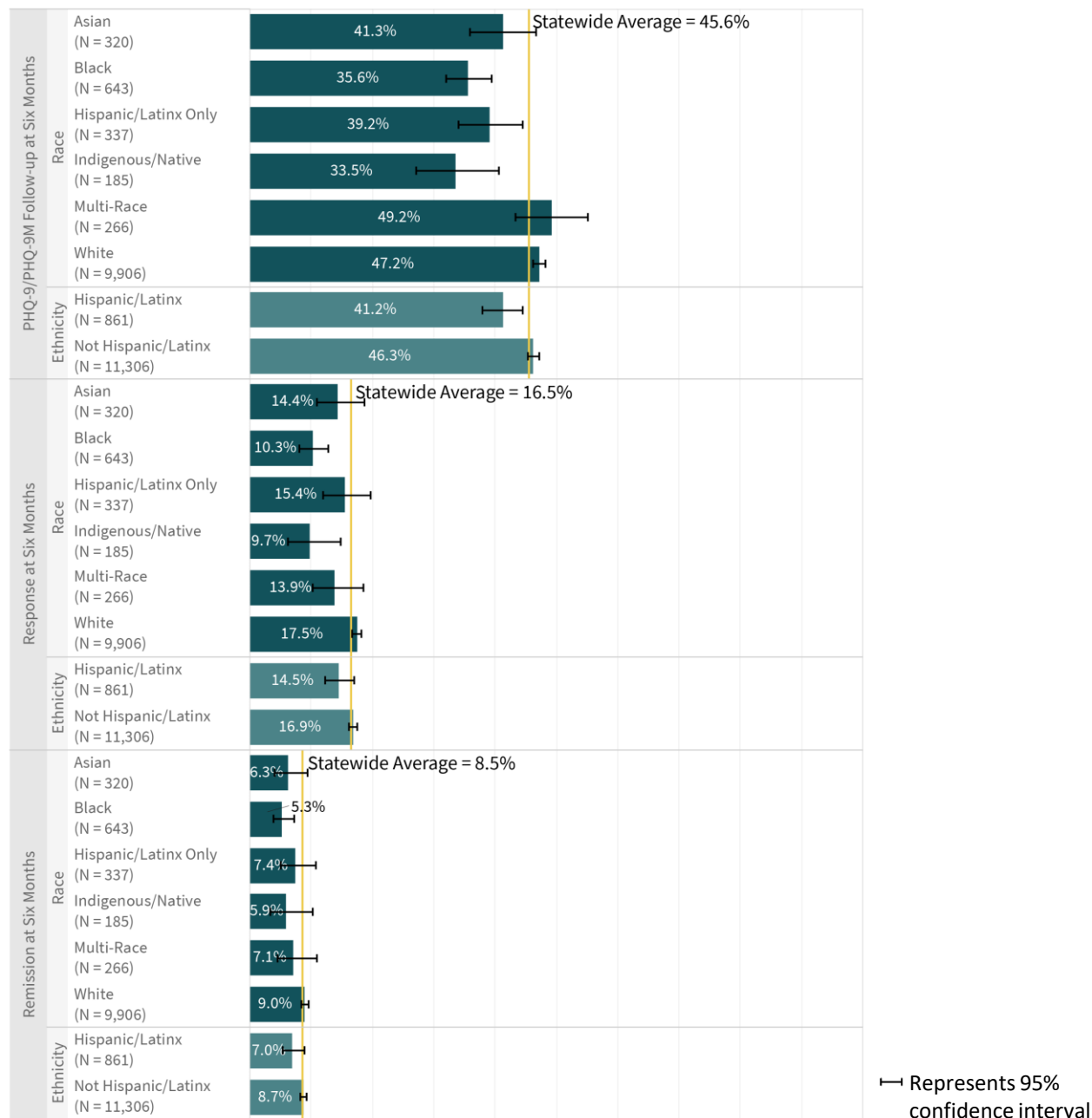
Patients from Ethiopia, Kenya, Somalia, Thailand or the United States make up 84 percent of the eligible population for the Adolescent Mental Health and/or Depression Screening measure.

Patients from Kenya have significantly lower rates of adolescent mental health screening compared to the statewide average.

ADOLESCENT DEPRESSION: SIX MONTH MEASURES

Race/Ethnicity Summary

2020 measurement year



PHQ-9/PHQ-9M Follow-up at Six Months

Patients who are Black, Indigenous/Native, who reported their race as Hispanic/Latinx or who are of Hispanic/Latinx ethnicity have significantly lower rates of follow-up at six months compared to the statewide average.

Response at Six Months

Patients who are Black or Indigenous/Native have significantly lower rates of response at six months compared to the statewide average.

Remission at Six Months

Patients who are Black have significantly lower rates of remission at six months compared to the statewide average.

The Native Hawaiian/ Pacific Islander category had less than 30 patients reported, which does not meet the reporting threshold for reliability.

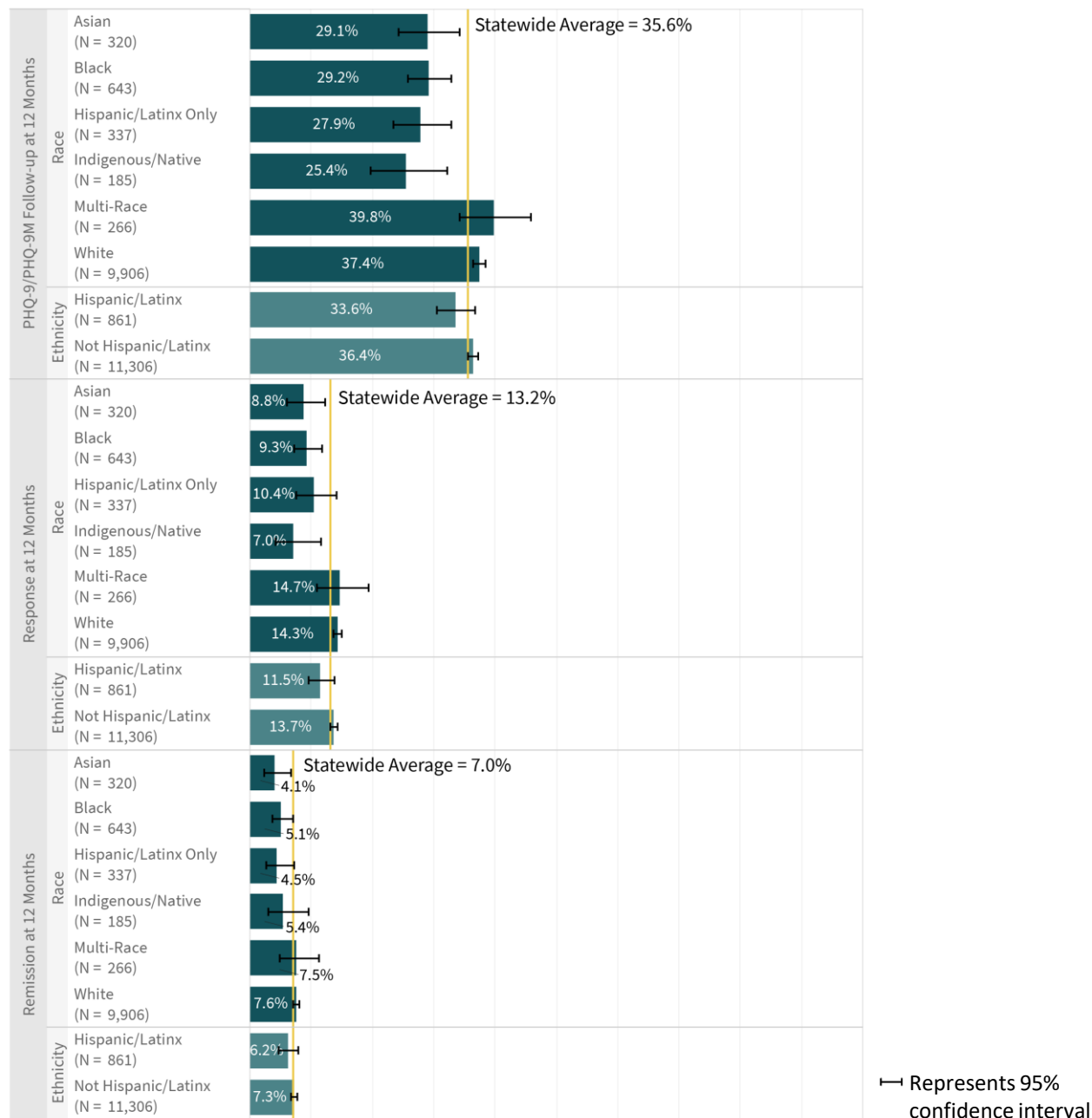
"Hispanic/Latinx Only" race category represents patients who only indicated that they are Hispanic/Latinx and did not provide any other race information.

"Hispanic/Latinx" ethnicity category represents all patients who indicated that they are Hispanic/Latinx, either with or without a separate race category.

ADOLESCENT DEPRESSION: 12 MONTH MEASURES

Race/Ethnicity Summary

2020 measurement year



PHQ-9/PHQ-9M Follow-up at 12 Months

Patients who are Asian, Black, Indigenous/Native or who reported their race as Hispanic/Latinx have significantly lower rates of follow-up at 12 months compared to the statewide average.

Patients who are White have a significantly higher rate of follow-up at 12 months compared to the statewide average.

Response at 12 Months

Patients who are Asian, Black or Indigenous/Native have significantly lower rates of response at 12 months compared to the statewide average.

The Native Hawaiian/ Pacific Islander category had less than 30 patients reported, which does not meet the reporting threshold for reliability.

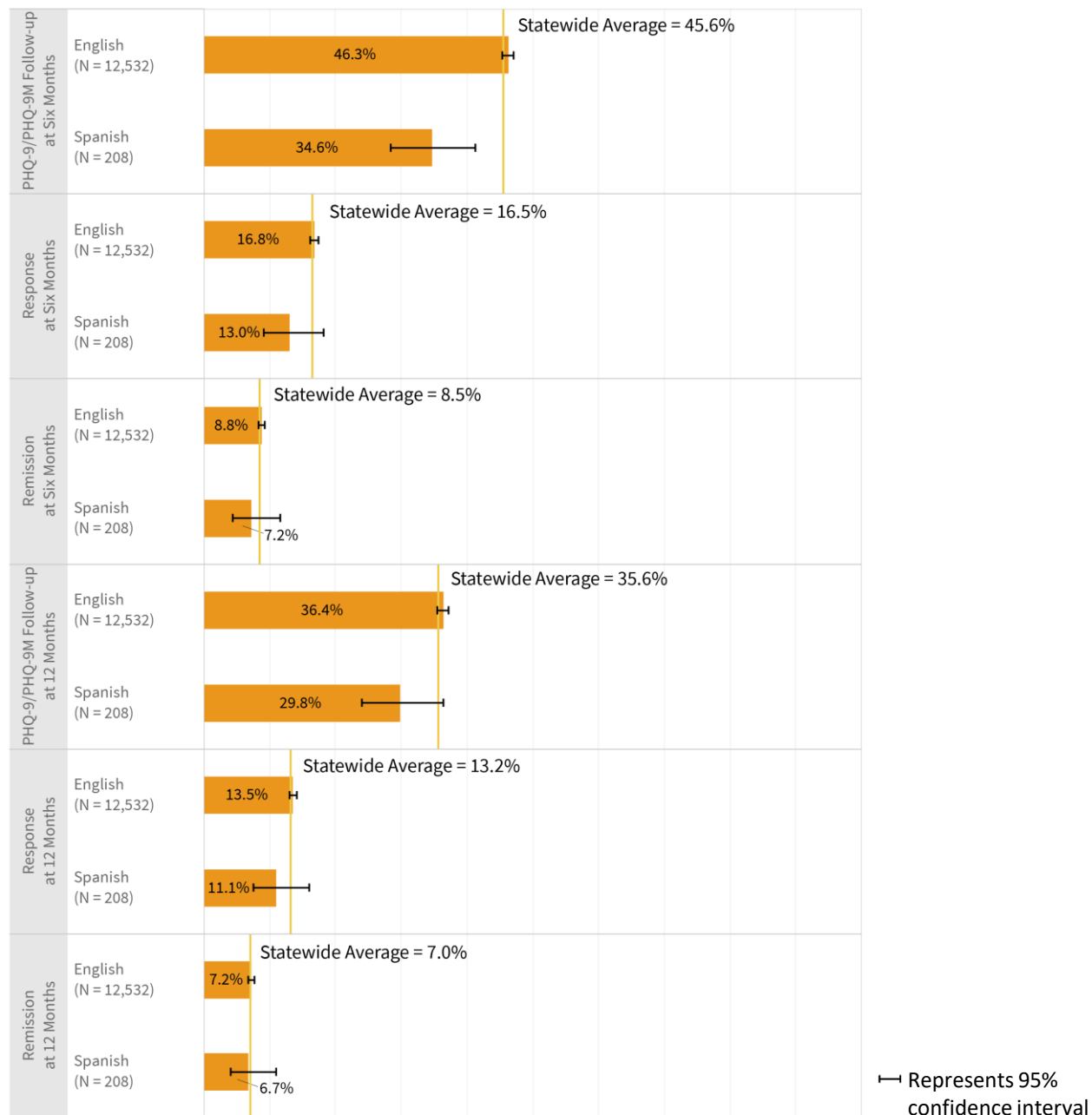
"Hispanic/Latinx Only" race category represents patients who only indicated that they are Hispanic/Latinx and did not provide any other race information.

"Hispanic/Latinx" ethnicity category represents all patients who indicated that they are Hispanic/Latinx, either with or without a separate race category.

ADOLESCENT DEPRESSION

Preferred Language Summary

2020 measurement year



Patients who prefer to speak English or Spanish make up 94 percent of the eligible population for the adolescent depression measures.

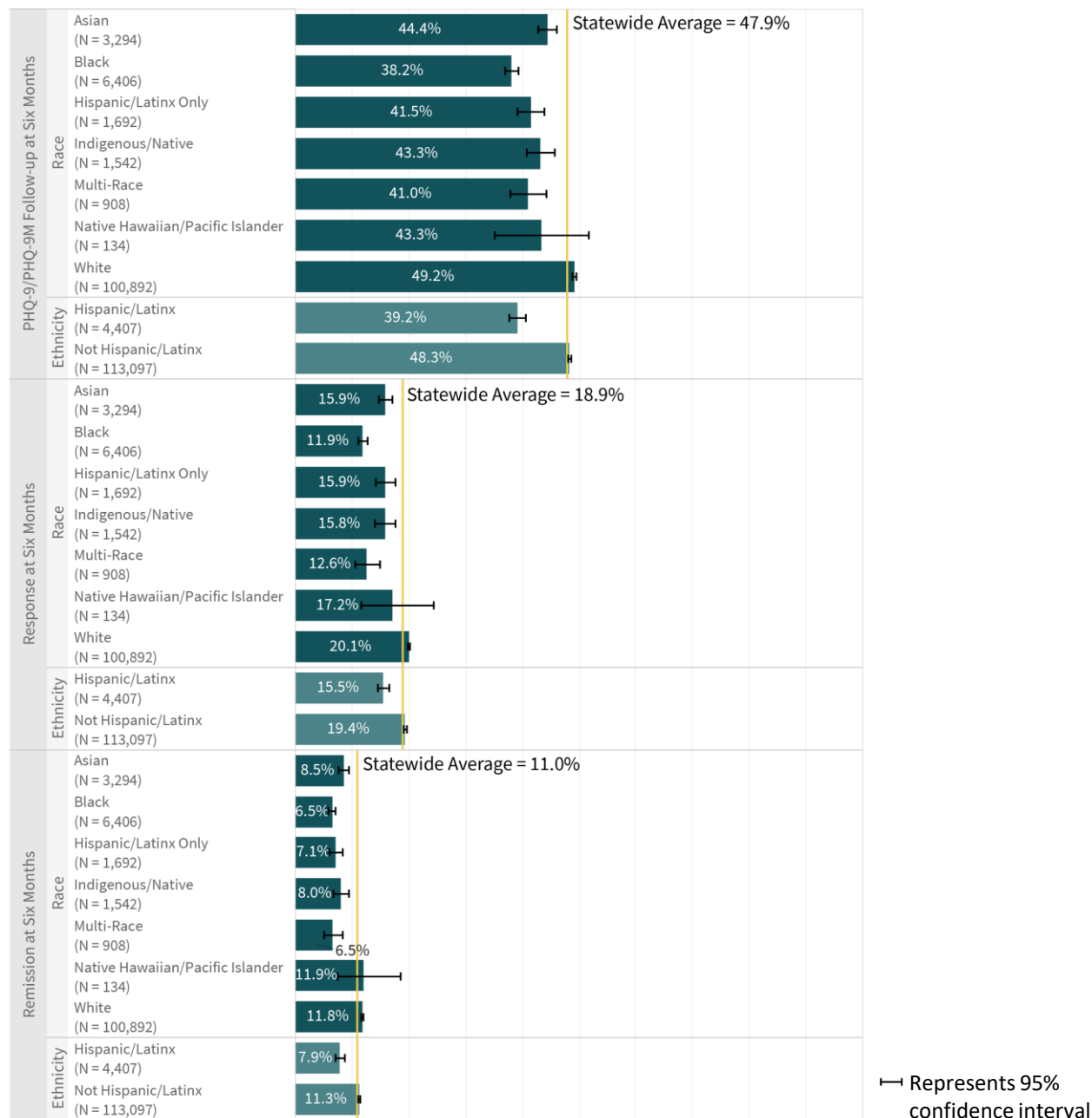
Patients who prefer to speak Spanish have significantly lower rates of follow-up at six months compared to the statewide average.

Note about Country of Origin: The United States was the only country with over 30 patients for the Adolescent Depression measures. As a result, this graph has been omitted.

ADULT DEPRESSION: SIX MONTH MEASURES

Race/Ethnicity Summary

2020 measurement year



PHQ-9/PHQ-9M Follow-up at Six Months

Aside from White and Native Hawaiian/Pacific Islander patients, patients from all other race categories and patients who are of Hispanic/Latinx ethnicity have significantly lower rates of follow-up at six months compared to the statewide average.

Response at Six Months

Aside from White and Native Hawaiian/Pacific Islander patients, patients from all other race categories and patients who are of Hispanic/Latinx ethnicity have significantly lower rates of response at six months compared to the statewide average.

Remission at Six Months

Aside from White and Native Hawaiian/Pacific Islander patients, patients from all other race categories and patients who are of Hispanic/Latinx ethnicity have significantly lower rates of remission at six months compared to the statewide average.

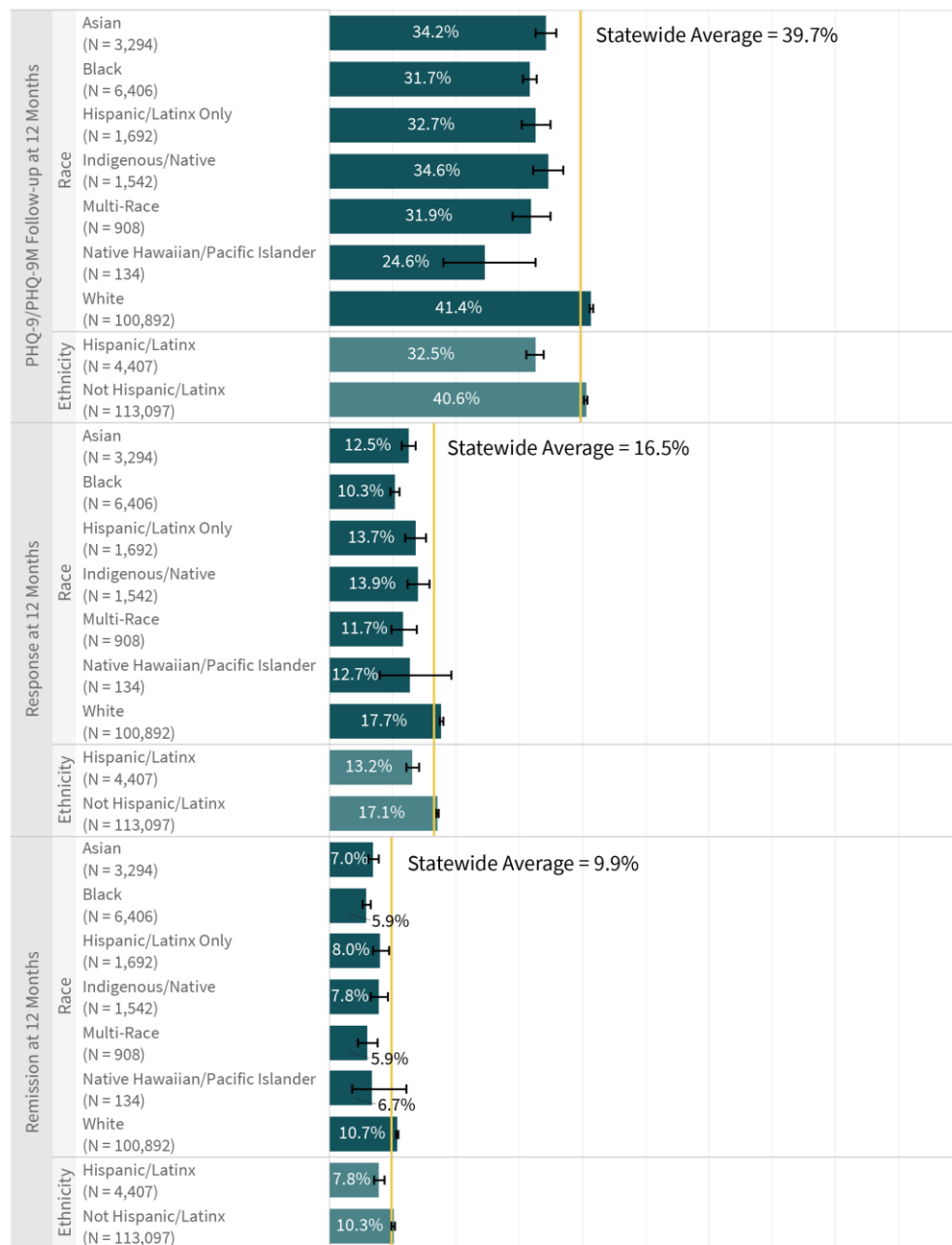
"Hispanic/Latinx Only" race category represents patients who only indicated that they are Hispanic/Latinx and did not provide any other race information.

"Hispanic/Latinx" ethnicity category represents all patients who indicated that they are Hispanic/Latinx, either with or without a separate race category.

ADULT DEPRESSION: 12 MONTH MEASURES

Race/Ethnicity Summary

2020 measurement year



— Represents 95% confidence interval

PHQ-9/PHQ-9M Follow-up at 12 Months

Aside from White patients, patients from all other race categories and patients who are of Hispanic/Latinx ethnicity have significantly lower rates of follow-up at 12 months compared to the statewide average.

Response at 12 Months

Aside from White and Native Hawaiian/Pacific Islander patients, patients from all other race categories and patients who are of Hispanic/Latinx ethnicity have significantly lower rates of response at 12 months compared to the statewide average.

Remission at 12 Months

Aside from White and Native Hawaiian/Pacific Islander patients, patients from all other race categories and patients who are of Hispanic/Latinx ethnicity have significantly lower rates of remission at 12 months compared to the statewide average.

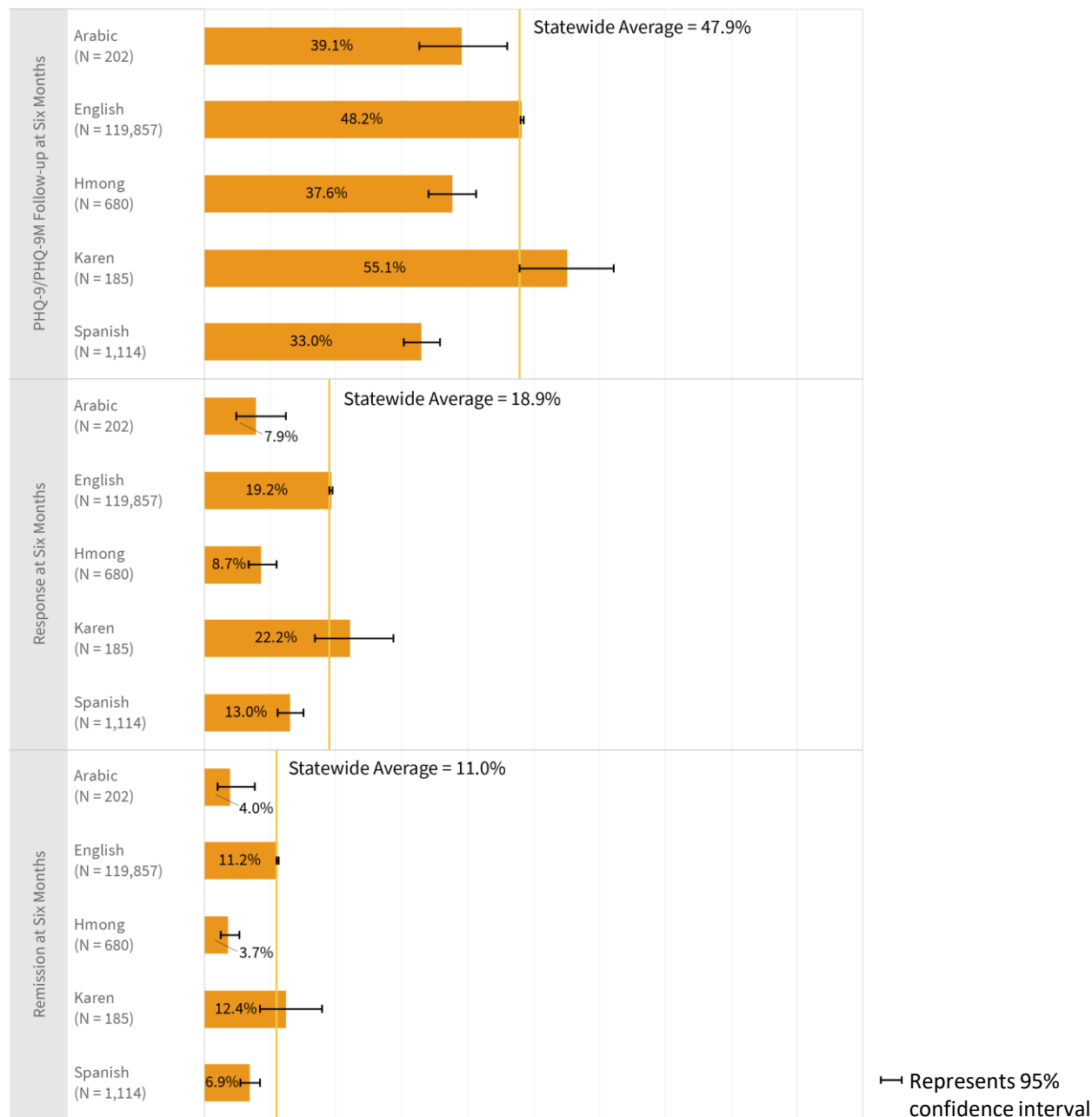
"Hispanic/Latinx Only" race category represents patients who only indicated that they are Hispanic/Latinx and did not provide any other race information.

"Hispanic/Latinx" ethnicity category represents all patients who indicated that they are Hispanic/Latinx, either with or without a separate race category.

ADULT DEPRESSION: SIX MONTH MEASURES

Preferred Language Summary

2020 measurement year



Patients who prefer to speak Arabic, English, Hmong, Karen or Spanish make up 97 percent of the eligible population for the adult depression measures.

PHQ-9/PHQ-9M Follow-up at Six Months

Patients who prefer to speak Arabic, Hmong or Spanish have significantly lower rates of follow-up at six months compared to the statewide average.

Response at Six Months

Patients who prefer to speak Arabic, Hmong or Spanish have significantly lower rates of response at six months compared to the statewide average.

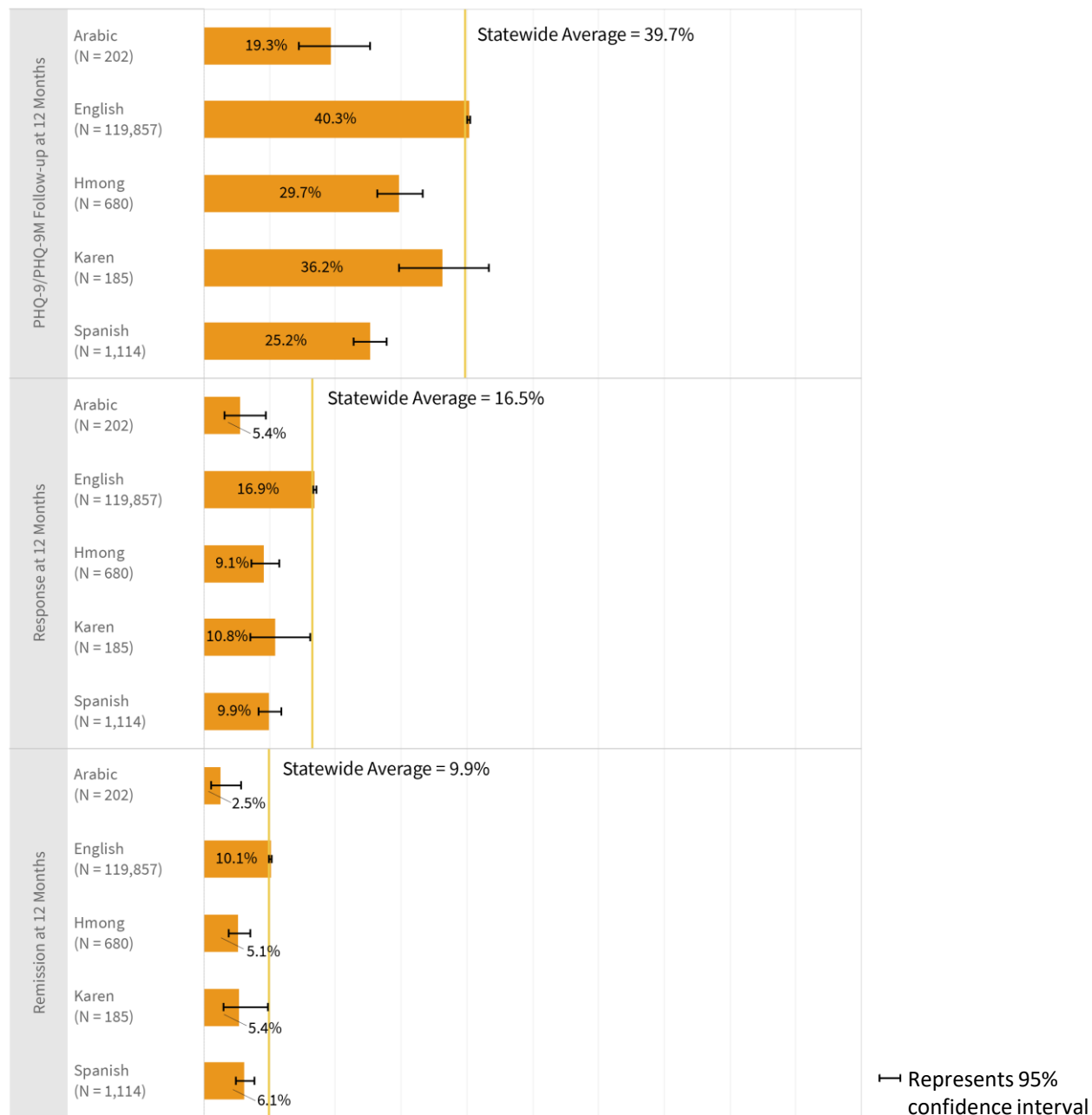
Remission at Six Months

Patients who prefer to speak Arabic, Hmong or Spanish significantly lower rates of remission at six months compared to the statewide average.

ADULT DEPRESSION: 12 MONTH MEASURES

Preferred Language Summary

2020 measurement year



PHQ-9/PHQ-9M Follow-up at 12 Months

Patients who prefer to speak Arabic, Hmong or Spanish have significantly lower rates of follow-up at 12 months compared to the statewide average.

Patients who prefer to speak English have a significantly higher rate of follow-up at 12 months compared to the statewide average.

Response at 12 Months

Patients who prefer to speak Arabic, Hmong or Spanish have significantly lower rates of response at 12 months compared to the statewide average.

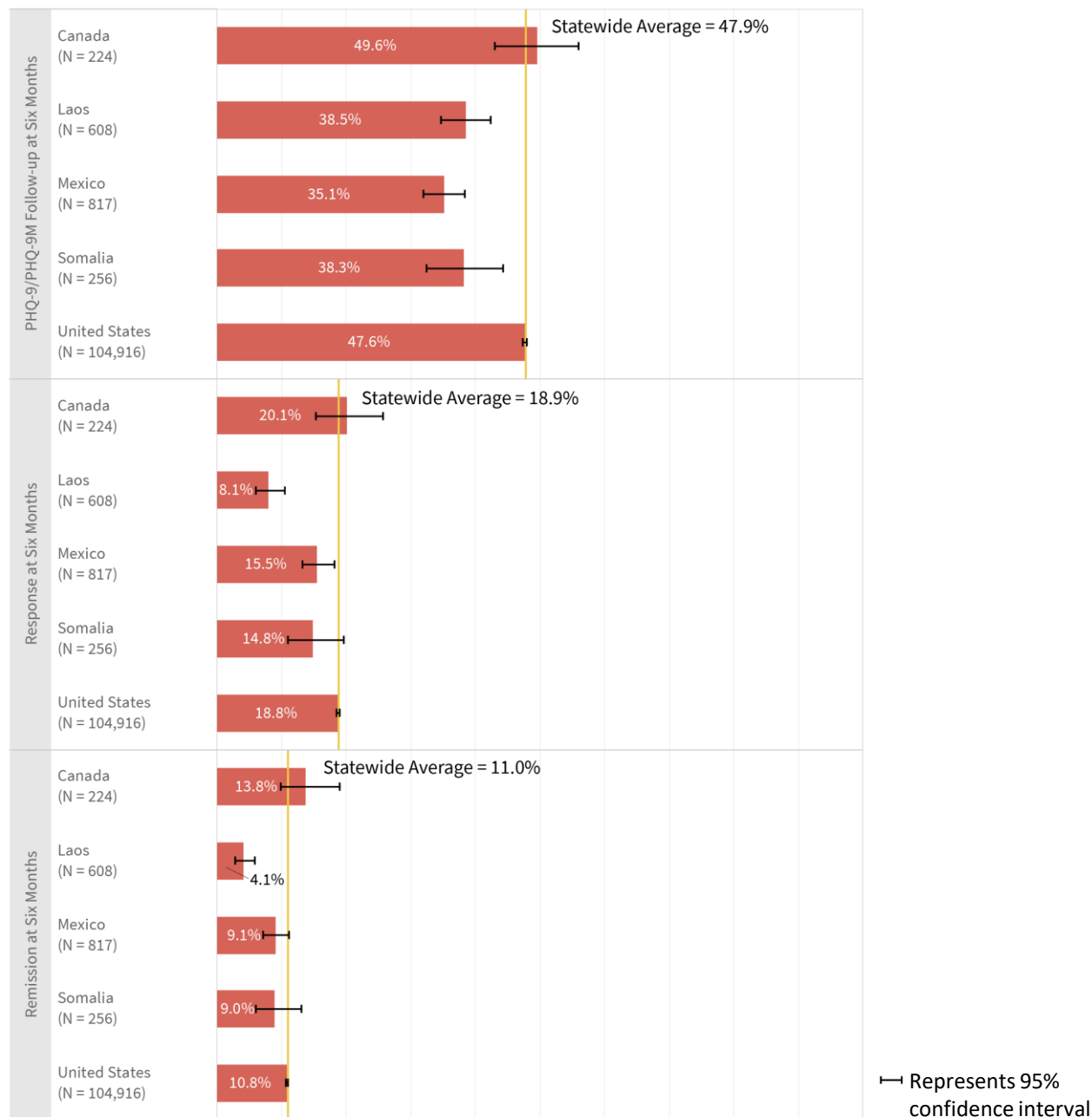
Remission at 12 Months

Patients who prefer to speak Arabic, Hmong or Spanish significantly lower rates of remission at 12 months compared to the statewide average.

ADULT DEPRESSION: SIX MONTH MEASURES

Country of Origin Summary

2020 measurement year



Patients from Canada, Laos, Mexico, Somalia or the United States make up 95 percent of the eligible population for the adult depression measures.

PHQ-9/PHQ-9M Follow-up at Six Months

Patients from Laos, Mexico and Somalia have significantly lower rates of follow-up at six months compared to the statewide average.

Response at Six Months

Patients from Laos and Mexico have significantly lower rates of response at six months compared to the statewide average.

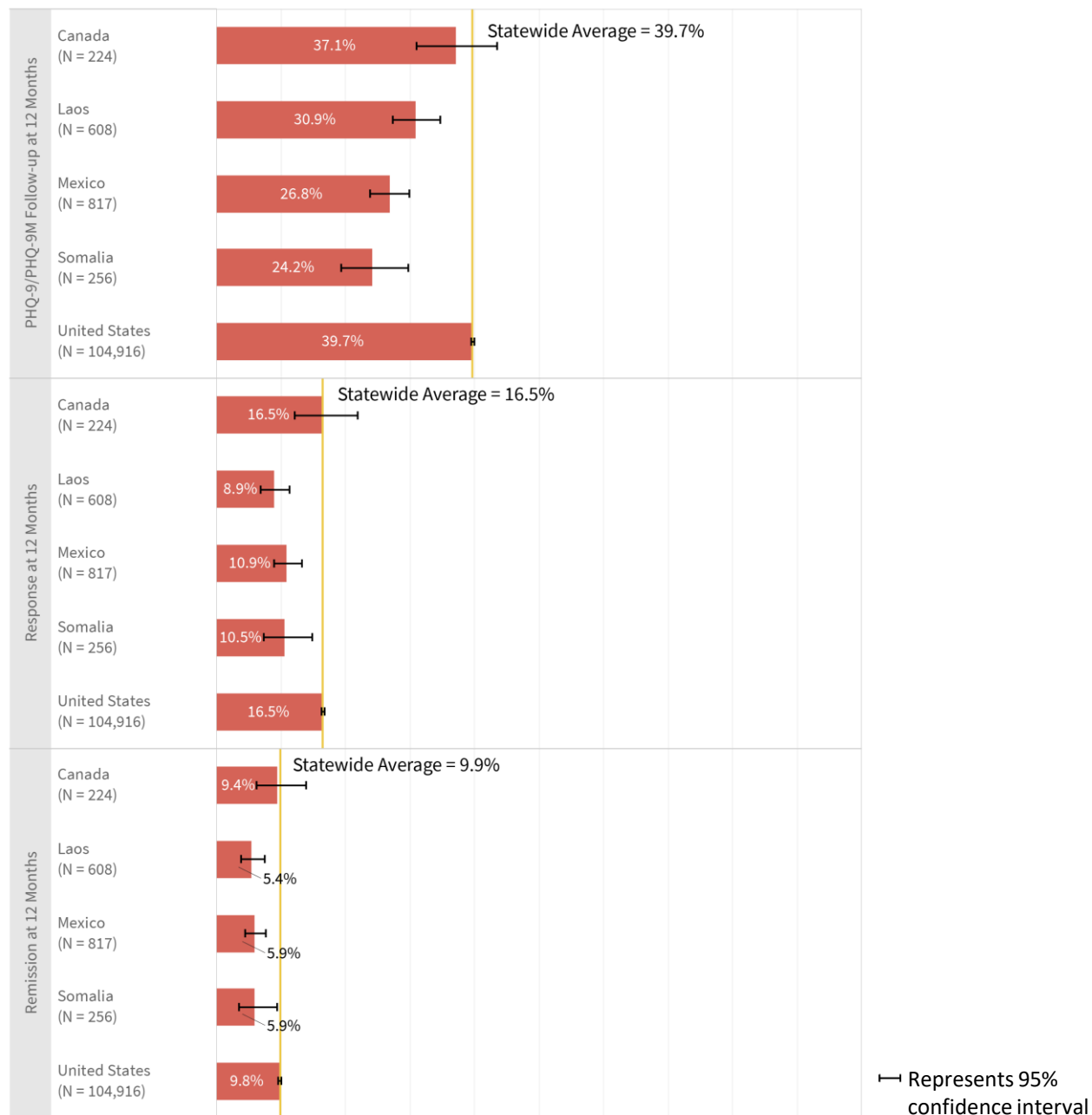
Remission at Six Months

Patients from Laos have significantly lower rates of remission at six months compared to the statewide average.

ADULT DEPRESSION: 12 MONTH MEASURES

Country of Origin Summary

2020 measurement year



PHQ-9/PHQ-9M Follow-up at 12 Months

Patients from Laos, Mexico and Somalia have significantly lower rates of follow-up at 12 months compared to the statewide average.

Response at 12 Months

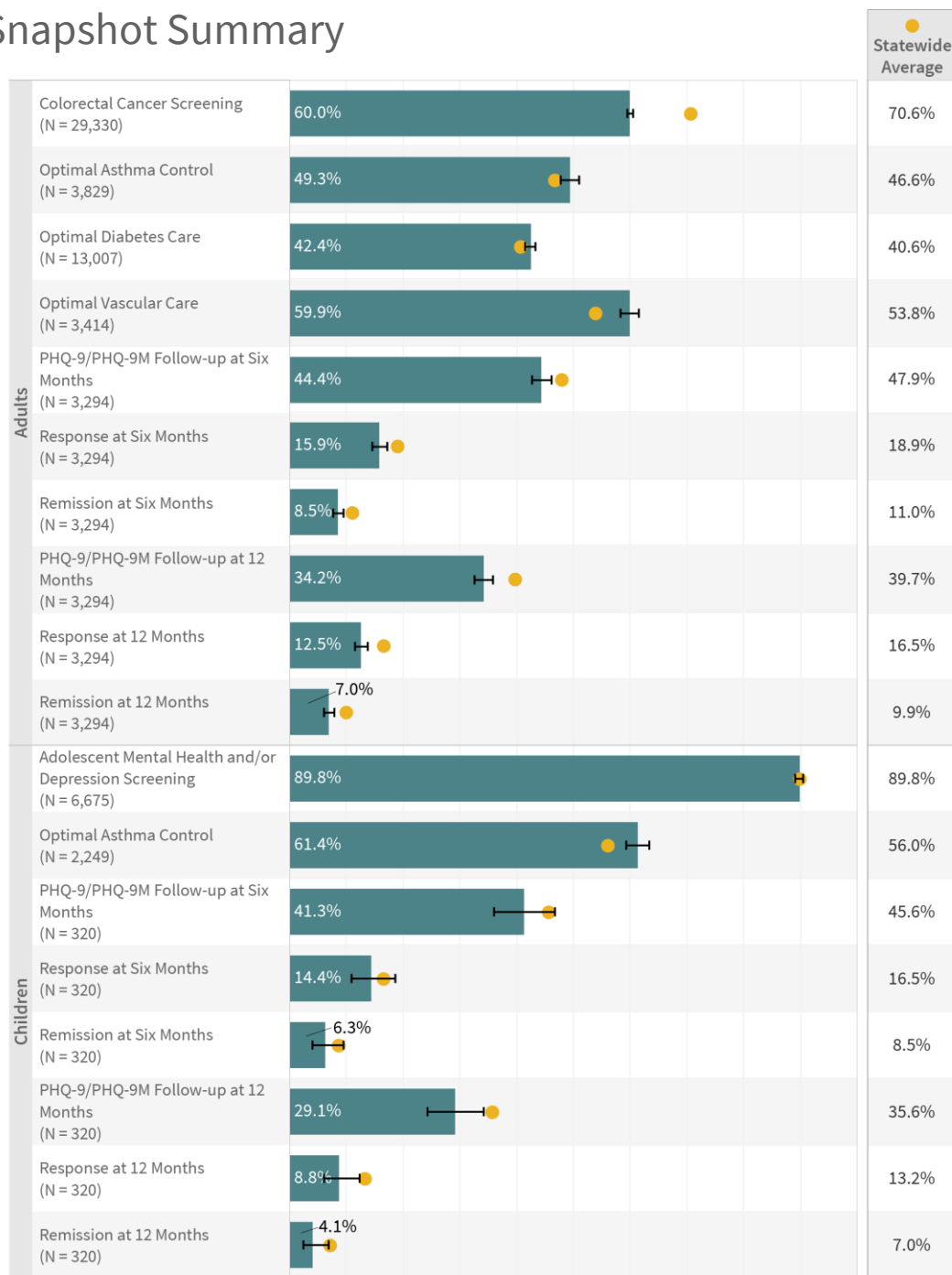
Patients from Laos, Mexico and Somalia have significantly lower rates of response at 12 months compared to the statewide average.

Remission at 12 Months

Patients from Laos, Mexico and Somalia have significantly lower rates of remission at 12 months compared to the statewide average.

Asian Patients

2020 Snapshot Summary



— Represents 95% confidence interval

Eliminating Disparities

Below is the number of additional Asian patients receiving optimal care needed to eliminate the disparity in outcomes for the following measures:

+ 3,174

Colorectal Cancer Screening

+ 117

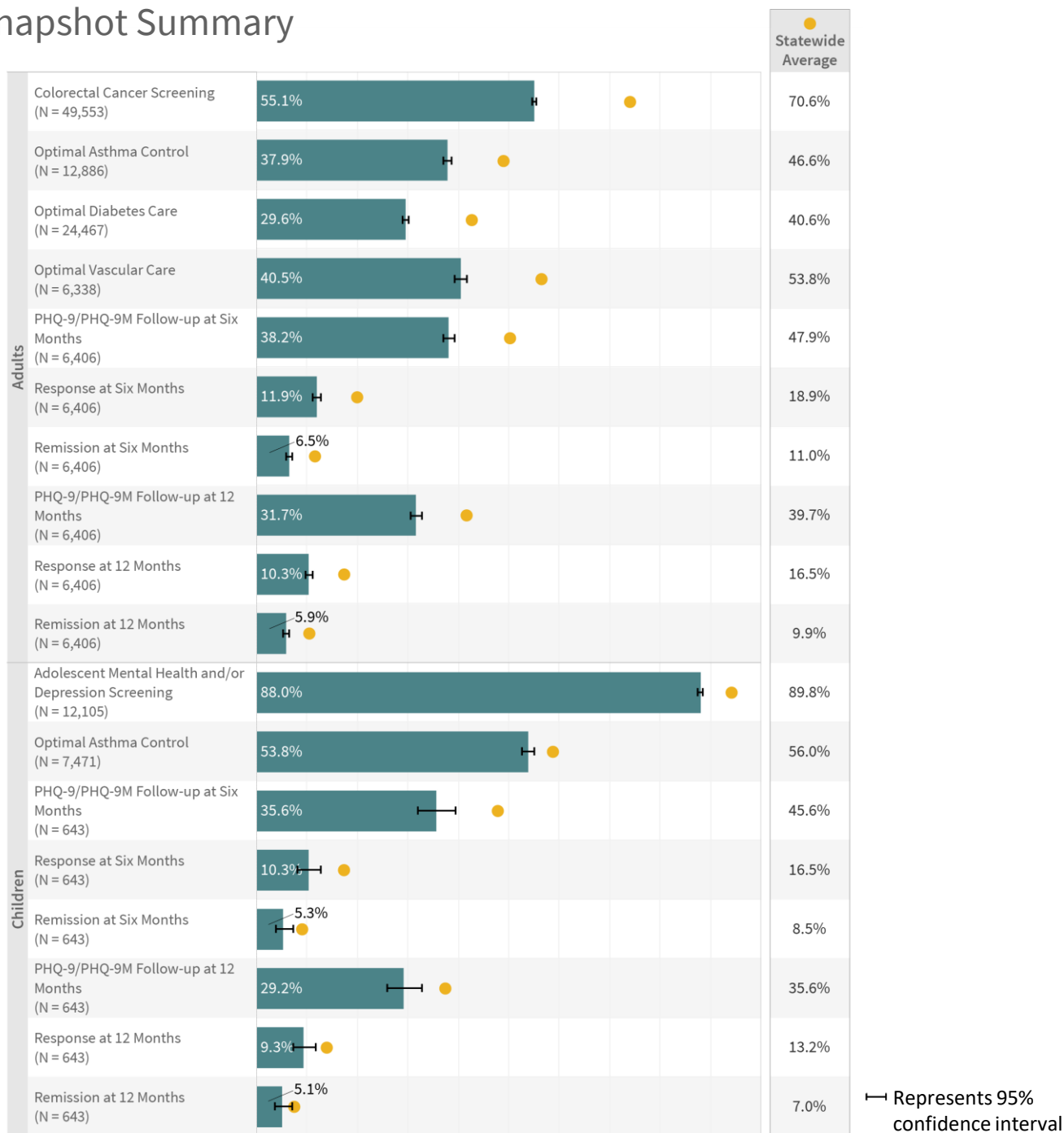
Adult Depression: PHQ-9/PHQ-9M Follow-up at Six Months

+ 82

Adult Depression: Remission at Six Months

Black Patients

2020 Snapshot Summary



Eliminating Disparities

Below is the number of additional Black patients receiving optimal care needed to eliminate the disparity in outcomes for the following measures:

+ 7,974

Colorectal Cancer Screening

+ 1,241

Optimal Asthma Control – Adults

+ 2,937

Optimal Diabetes Care

+ 872

Optimal Vascular Care

+ 183

Optimal Asthma Control – Children

+ 238

Adolescent Mental Health and/or Depression Screening

+ 67

Adolescent Depression: PHQ-9/PHQ-9M Follow-up at Six Months

+ 22

Adolescent Depression: Remission at Six Months

+ 656

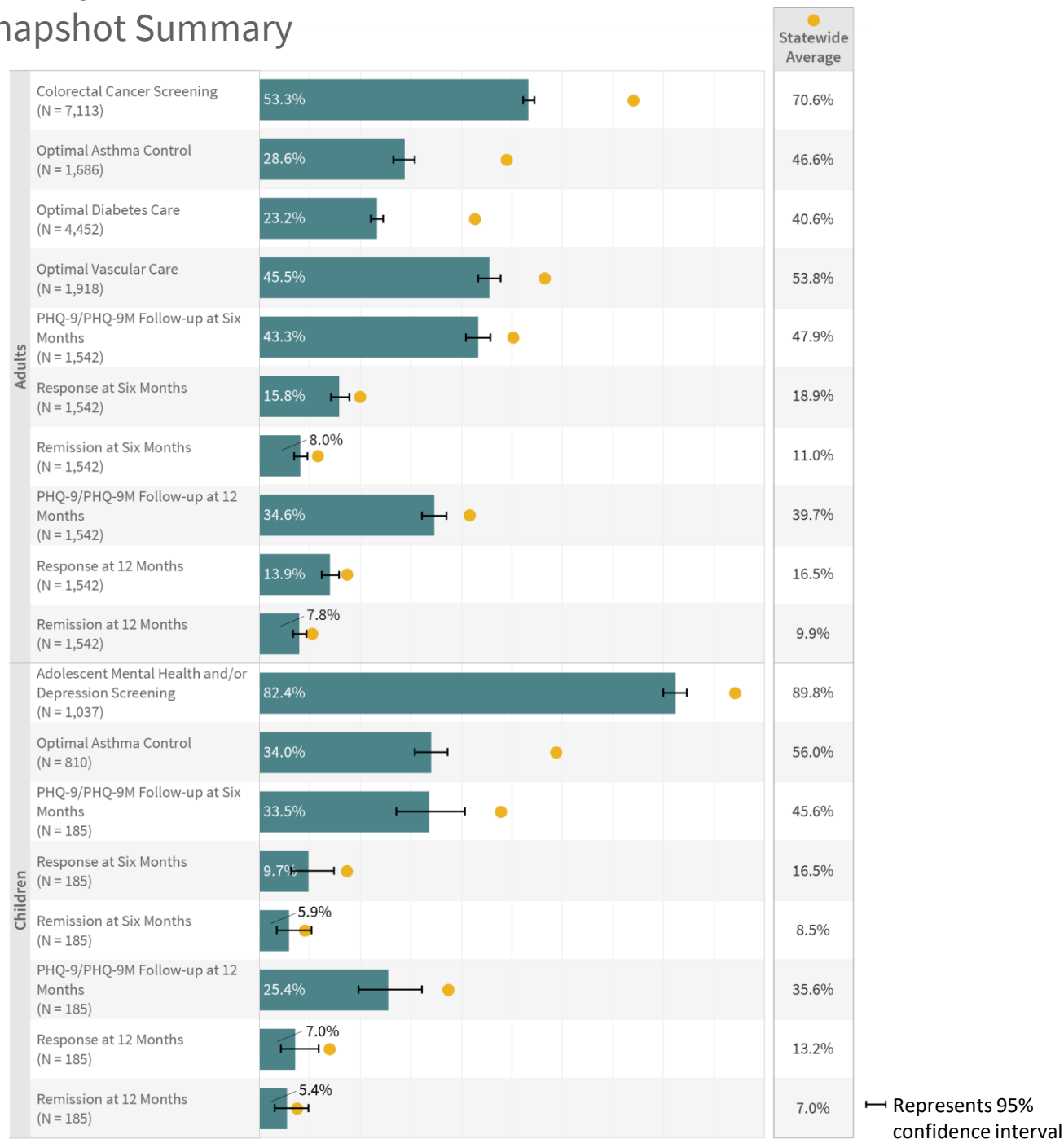
Adult Depression: PHQ-9/PHQ-9M Follow-up at Six Months

+302

Adult Depression: Remission at Six Months

Indigenous/Native Patients

2020 Snapshot Summary



Eliminating Disparities

Below is the number of additional Indigenous/Native patients receiving optimal care needed to eliminate the disparity in outcomes for the following measures:

+ 1,233

Colorectal Cancer Screening

+ 307

Optimal Asthma Control - Adults

+ 788

Optimal Diabetes Care

+ 161

Optimal Vascular Care

+ 181

Optimal Asthma Control – Children

+ 77

Adolescent Mental Health and/or Depression Screening

+ 23

Adolescent Depression: PHQ-9/PHQ-9M Follow-up at Six Months

+ 72

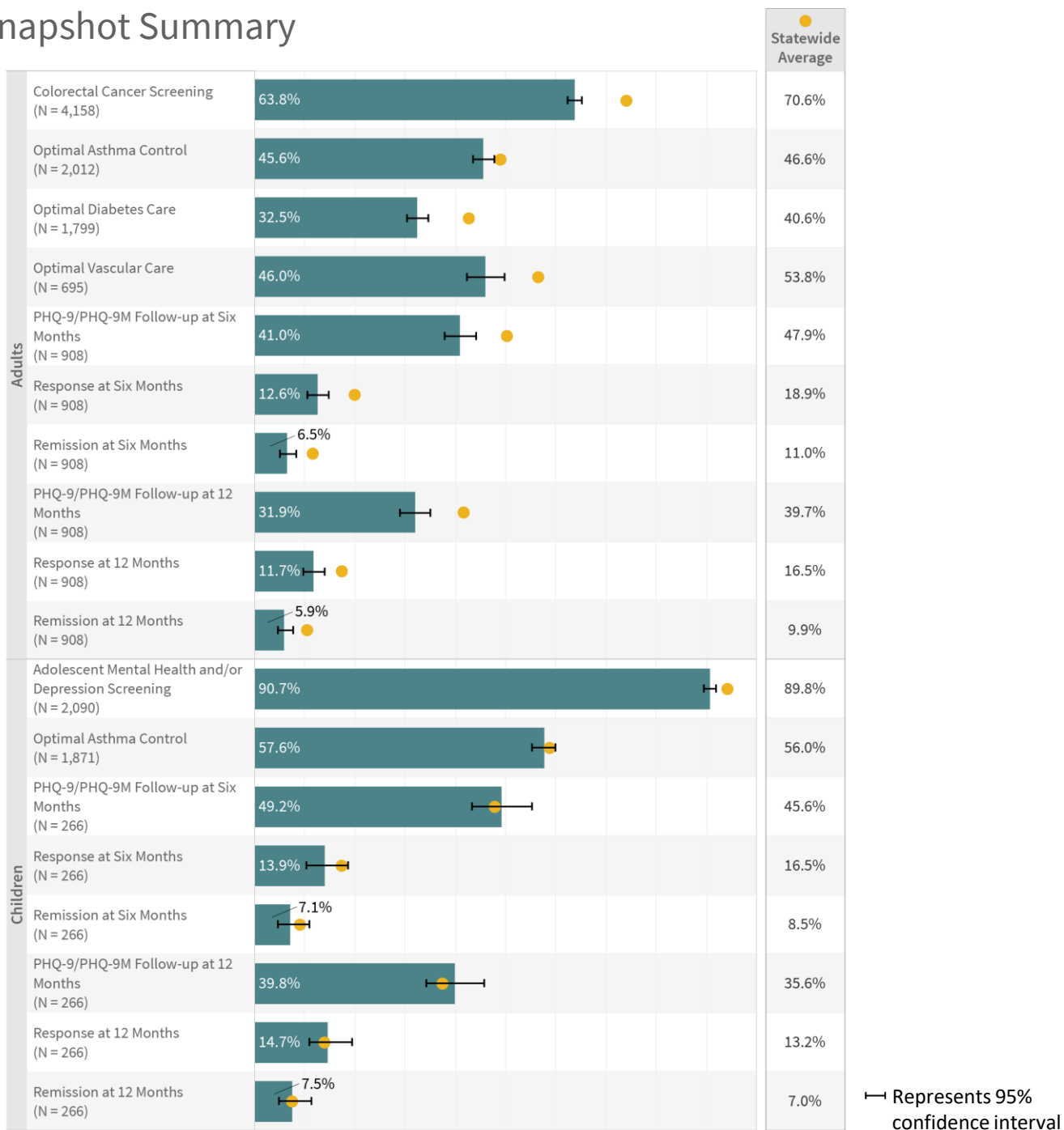
Adult Depression: PHQ-9/PHQ-9M Follow-up at Six Months

+46

Adult Depression: Remission at Six Months

Multi-Race Patients

2020 Snapshot Summary



Eliminating Disparities

Below is the number of additional Multi-Race patients receiving optimal care needed to eliminate the disparity in outcomes for the following measures:

+ 282

Colorectal Cancer Screening

+ 148

Optimal Diabetes Care

+ 54

Optimal Vascular Care

+ 63

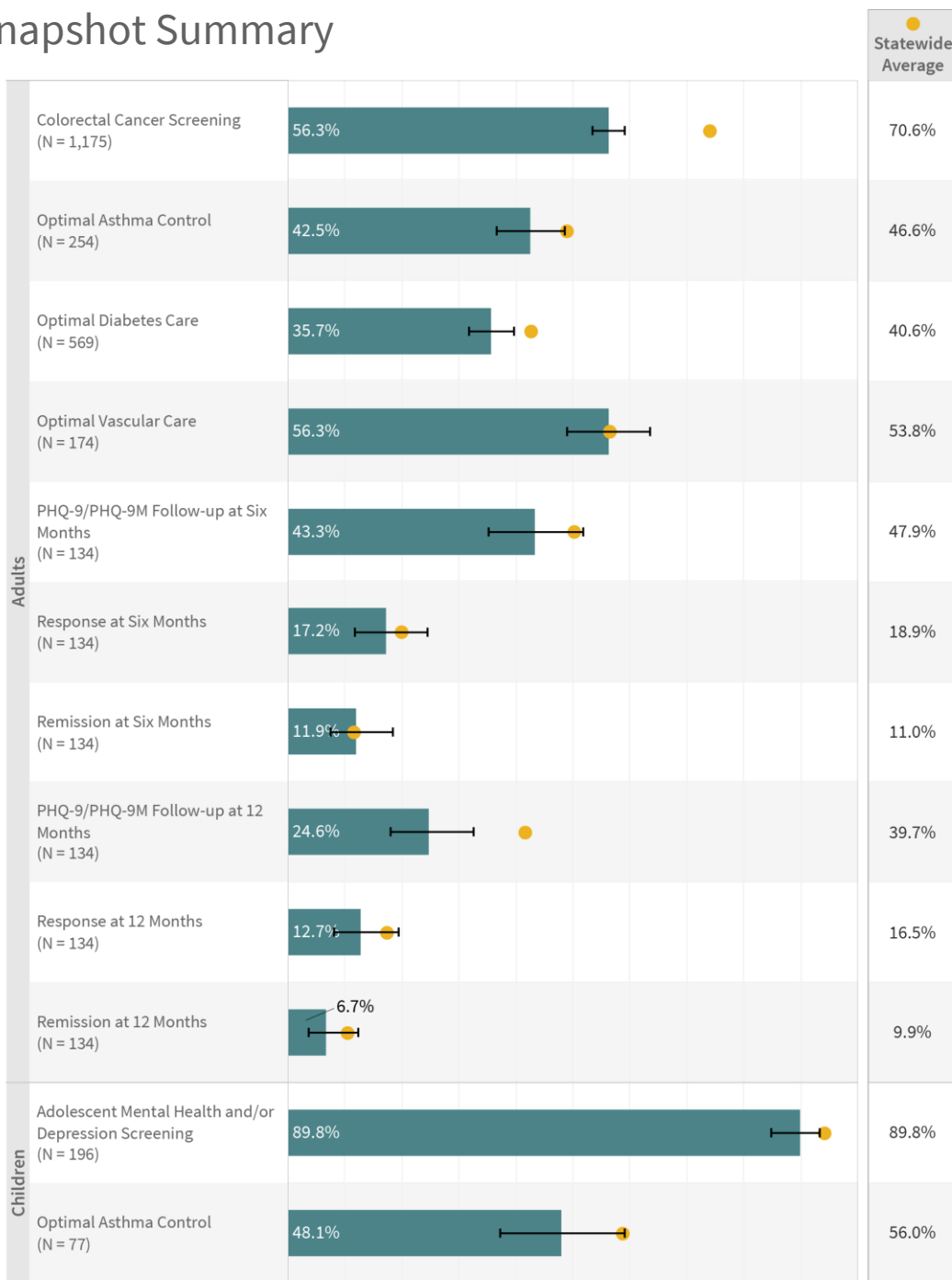
Adult Depression: PHQ-9/PHQ-9M Follow-up at Six Months

+41

Adult Depression: Remission at Six Months

Native Hawaiian/Pacific Islander Patients

2020 Snapshot Summary



— Represents 95% confidence interval

Eliminating Disparities

Below is the number of additional Native Hawaiian/Pacific Islander patients receiving optimal care needed to eliminate the disparity in outcomes for the following measures:

+ 168

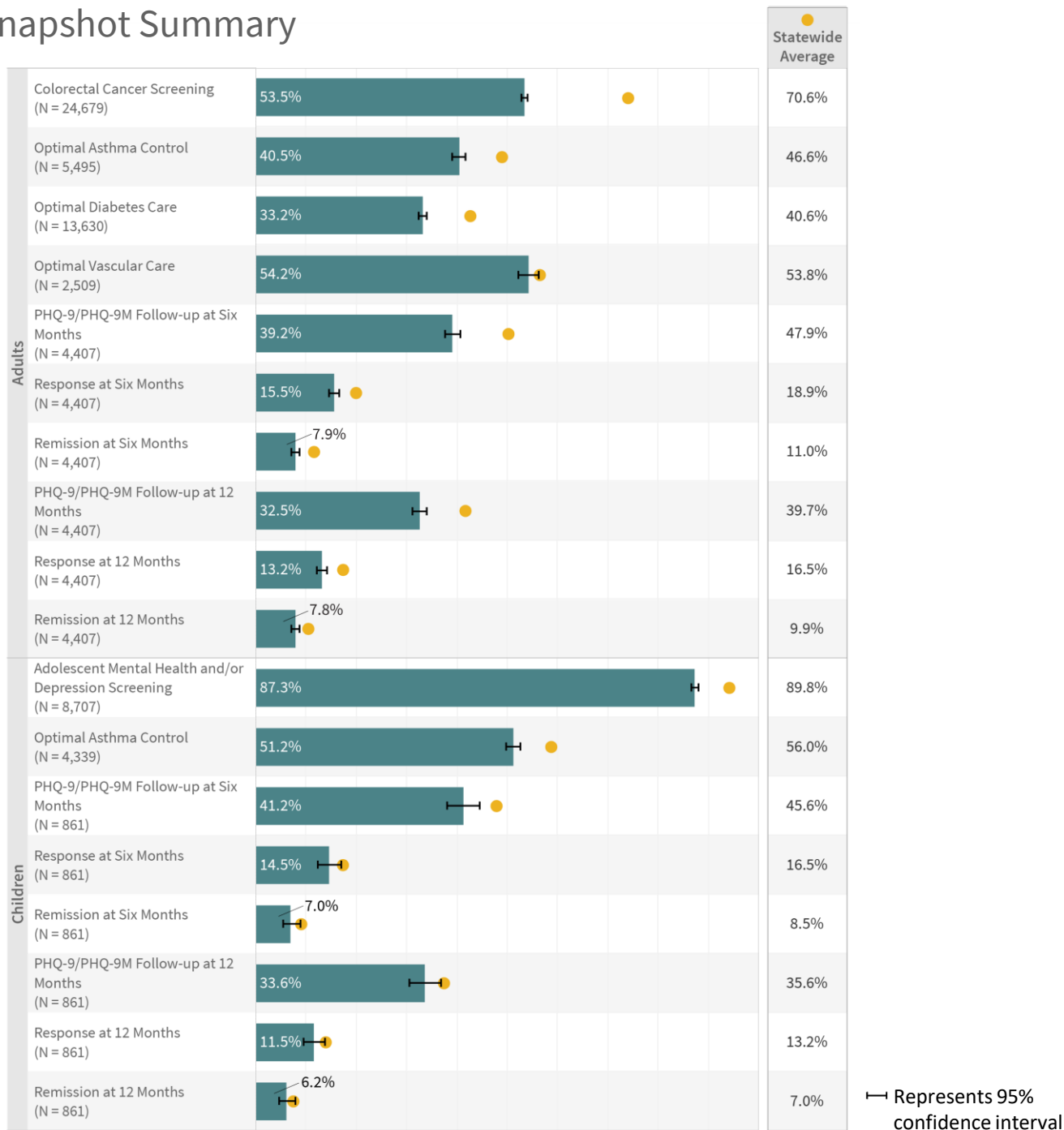
Colorectal Cancer Screening

+ 28

Optimal Diabetes Care

Hispanic/Latinx Patients

2020 Snapshot Summary



Eliminating Disparities

Below is the number of additional Hispanic/Latinx patients receiving optimal care needed to eliminate the disparity in outcomes for the following measures:

+ 4,291

Colorectal Cancer Screening

+ 353

Optimal Asthma Control - Adults

+ 1,065

Optimal Diabetes Care

+224

Optimal Asthma Control – Children

+ 229

Adolescent Mental Health and/or Depression Screening

+ 40

Adolescent Depression: PHQ-9/PHQ-9M Follow-up at Six Months

+ 397

Adult Depression: PHQ-9/PHQ-9M Follow-up at Six Months

+140

Adult Depression: Remission at Six Months

Statewide Summary by Race and Hispanic Ethnicity

Rate comparison of race/ethnicity averages to statewide average

Measure		Statewide Rate	RACE						ETHNICITY		
			Asian	Black	Hispanic/ Latinx Only	Indigenous / Native	Multi-Race	Native Hawaiian/ Pacific Islander	White	Hispanic/ Latinx	Not Hispanic/ Latinx
Colorectal Cancer Screening		70.6%	60.0% ▼	55.1% ▼	57.5% ▼	53.3% ▼	63.8% ▼	56.3% ▼	72.4% ▲	53.5% ▼	71.3% ▲
Optimal Asthma Control – Adults		46.6%	49.3% ▲	37.9% ▼	44.6% ●	28.6% ▼	45.6% ●	42.5% ●	48.1% ▲	40.5% ▼	47.0% ●
Optimal Diabetes Care		40.6%	42.4% ▲	29.6% ▼	32.8% ▼	23.2% ▼	32.5% ▼	35.7% ▼	42.4% ▲	33.2% ▼	41.0% ▲
Optimal Vascular Care		53.8%	59.9% ▲	40.5% ▼	56.2% ●	45.5% ▼	46.0% ▼	56.3% ●	54.5% ▲	54.2% ●	53.9% ●
Optimal Asthma Control – Children		56.0%	61.4% ▲	53.8% ▼	54.8% ●	34.0% ▼	57.6% ●	48.1% ●	56.8% ●	51.2% ▼	56.6% ●
Adolescent Mental Health and/or Depression Screening		89.8%	89.8% ●	88.0% ▼	87.9% ▼	82.4% ▼	90.7% ●	89.8% ●	89.8% ●	87.3% ▼	89.8% ●
ADOLESCENT DEPRESSION	PHQ-9/PHQ-9M Follow-up at Six Months	45.6%	41.3% ●	35.6% ▼	39.2% ▼	33.5% ▼	49.2% ●	NR	47.2% ●	41.2% ▼	46.3% ●
	Response at Six Months	16.5%	14.4% ●	10.3% ▼	15.4% ●	9.7% ▼	13.9% ●	NR	17.5% ●	14.5% ●	16.9% ●
	Remission at Six Months	8.5%	6.3% ●	5.3% ▼	7.4% ●	5.9% ●	7.1% ●	NR	9.0% ●	7.0% ●	8.7% ●
	PHQ-9/PHQ-9M Follow-up at 12 Months	35.6%	29.1% ▼	29.2% ▼	27.9% ▼	25.4% ▼	39.8% ●	NR	37.4% ▲	33.6% ●	36.4% ●
	Response at 12 Months	13.2%	8.8% ▼	9.3% ▼	10.4% ●	7.0% ▼	14.7% ●	NR	14.3% ●	11.5% ●	13.7% ●
	Remission at 12 Months	7.0%	4.1% ●	5.1% ●	4.5% ●	5.4% ●	7.5% ●	NR	7.6% ●	6.2% ●	7.3% ●

▼ Below statewide average ● Average ▲ Above statewide average NR = Not reportable (< 30 patients)

Statewide Summary by Race and Hispanic Ethnicity Continued

Rate comparison of race/ethnicity averages to statewide average

Measure		Statewide Rate	RACE							ETHNICITY	
			Asian	Black	Hispanic/ Latinx Only	Indigenous / Native	Multi-Race	Native Hawaiian/ Pacific Islander	White	Hispanic/ Latinx	Not Hispanic/ Latinx
ADULT DEPRESSION	PHQ-9/PHQ-9M Follow-up at Six Months	47.9%	44.4% ▼	38.2% ▼	41.5% ▼	43.3% ▼	41.0% ▼	43.3% ●	49.2% ▲	39.2% ▼	48.3% ●
	Response at Six Months	18.9%	15.9% ▼	11.9% ▼	15.9% ▼	15.8% ▼	12.6% ▼	17.2% ●	20.1% ▲	15.5% ▼	19.4% ●
	Remission at Six Months	11.0%	8.5% ▼	6.5% ▼	7.1% ▼	8.0% ▼	6.5% ▼	11.9% ●	11.8% ▲	7.9% ▼	11.3% ●
	PHQ-9/PHQ-9M Follow-up at 12 Months	39.7%	34.2% ▼	31.7% ▼	32.7% ▼	34.6% ▼	31.9% ▼	24.6% ▼	41.4% ▲	32.5% ▼	40.6% ▲
	Response at 12 Months	16.5%	12.5% ▼	10.3% ▼	13.7% ▼	13.9% ▼	11.7% ▼	12.7% ●	17.7% ▲	13.2% ▼	17.1% ▲
	Remission at 12 Months	9.9%	7.0% ▼	5.9% ▼	8.0% ▼	7.8% ▼	5.9% ▼	6.7% ●	10.7% ▲	7.8% ▼	10.3% ▲

▼ Below statewide average

● Average

▲ Above statewide average

NR = Not reportable (< 30 patients)

DEFINITIONS & METHODOLOGY

MEASURE DEFINITIONS

OPTIMAL DIABETES CARE

The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes and whose diabetes was optimally managed during the measurement period as defined by achieving all of the following:

- HbA1c less than 8.0 mg/dL
- Blood pressure less than 140/90 mm Hg
- On a statin medication, unless allowed contraindications or exceptions are present
- Non-tobacco user
- Patient with ischemic vascular disease on daily aspirin or anti-platelets, unless allowed contraindications or exceptions are present

OPTIMAL VASCULAR CARE

The percentage of patients 18-75 years of age who had a diagnosis of ischemic vascular disease (IVD) and whose IVD was optimally managed during the measurement period as defined by achieving all of the following:

- Blood pressure less than 140/90 mm Hg
- On a statin medication, unless allowed contraindications or exceptions are present
- Non-tobacco user
- On daily aspirin or anti-platelets, unless allowed contraindications or exceptions are present

OPTIMAL ASTHMA CONTROL - ADULTS

The percentage of adults 18-50 years of age who had a diagnosis of asthma and whose asthma was optimally controlled during the measurement period as defined by achieving both of the following:

- Asthma well-controlled as defined by the most recent asthma control tool result available during the measurement period
- Patient not at elevated risk of exacerbation as defined by less than two emergency department visits and/or hospitalizations due to asthma in the last 12 months

OPTIMAL ASTHMA CONTROL - CHILDREN

The percentage of children 5-17 years of age who had a diagnosis of asthma and whose asthma was optimally controlled during the measurement period as defined by achieving both of the following:

- Asthma well-controlled as defined by the most recent asthma control tool result available during the measurement period
- Patient not at elevated risk of exacerbation as defined by less than two emergency department visits and/or hospitalizations due to asthma in the last 12 months

COLORECTAL CANCER SCREENING

The percentage of adults ages 50-75 who are up-to-date with the appropriate screening for colorectal cancer. Appropriate screenings include one of the following:

- Colonoscopy during the measurement period or the nine years prior; **OR**
- Flexible sigmoidoscopy during the measurement year or the four years prior; **OR**
- CT colonography during the measurement year or the four years prior; **OR**
- Fecal immunochemical test (FIT)-DNA during the measurement year or the two years prior; **OR**
- Guaiac-based fecal occult blood test (gFOBT) or FIT during the measurement year

MEASURE DEFINITIONS

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

The percentage of patients ages 12-17 who were screened for mental health and/or depression at a well-child visit using a specified tool. *Note: Adolescents diagnosed with depression are excluded from this measure.*

SIX MONTH MEASURES

Adults & Adolescents

- **PHQ-9/PHQ-9M Follow-up at Six Months:** The percentage of adults (18 years and older) or adolescents (12-17 years) with depression who have a completed PHQ-9/PHQ-9M tool within six months after the index event (+/- 60 days)
- **Response at Six Months:** The percentage of adults (18 years and older) or adolescents (12-17 years) with depression who demonstrated a response to treatment (at least 50 percent improvement) six months after the index event (+/- 60 days)
- **Remission at Six Months:** The percentage of adults (18 years and adolescents (12-17 years) with depression who reached remission (PHQ-9/PHQ-9M score less than five) six months after the index event (+/- 60 days)

12 MONTH MEASURES

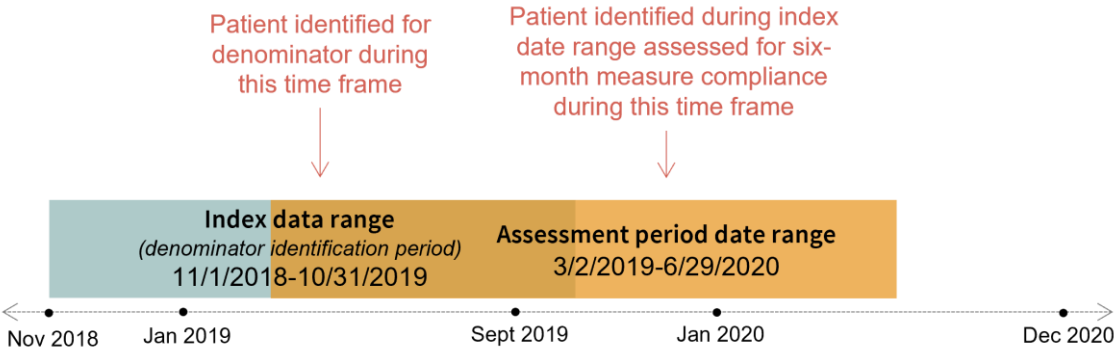
Adults & Adolescents

- **PHQ-9/PHQ-9M Follow-up at 12 Months:** The percentage of adults (18 years and older) or adolescents (12-17 years) with depression who have a completed PHQ-9/PHQ-9M tool within 12 months after the index event (+/- 60 days)
- **Response at 12 Months:** The percentage of adults (18 years and older) or adolescents (12-17 years) with depression who demonstrated a response to treatment (at least 50 percent improvement) 12 months after the index event (+/- 60 days)
- **Remission at 12 Months:** The percentage of adults (18 years and adolescents (12-17 years) with depression who reached remission (PHQ-9/PHQ-9M score less than five) 12 months after the index event (+/- 60 days)

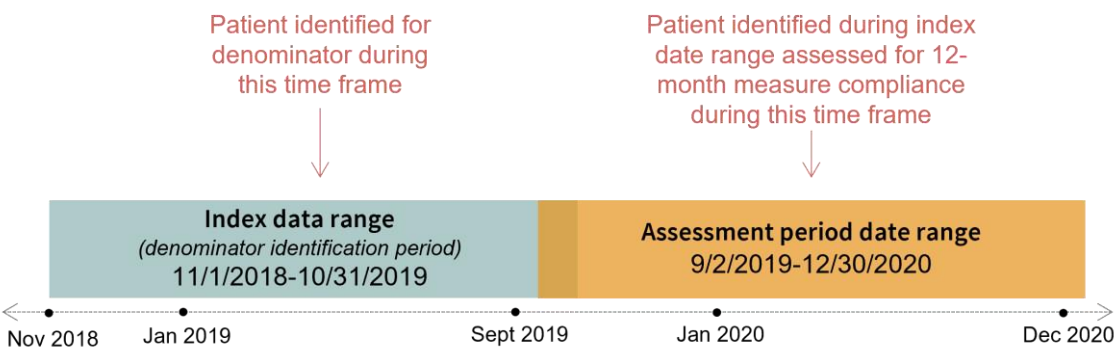
OVERVIEW OF DEPRESSION MEASURES

The depression measures are unique in that the time period for identifying eligible patients for the denominators do not follow the typical measurement period that the other quality measures do. The depression measures are longitudinal in design, meaning patients are followed through a period of time and assessed for the desired outcome. A patient is first identified for the denominator during the denominator identification period (shown below), which primarily occurs two years prior to when the data are submitted. The assessment period (shown below) is the time in which those patients identified in the denominator identification period are assessed for the desired outcome and primarily occurs in the year prior to data submission.

Six-Month Measure Timeline



12-Month Measure Timeline



DATA COLLECTION AND MEASURE CALCULATION

The measures featured in this report use data submitted directly to MNCM by medical groups and clinics.

ELIGIBLE POPULATION SPECIFICATIONS

The eligible population for each measure is identified by a medical group on behalf of their individual clinics. MNCM's 2020 Data Collection Guides provide technical specifications for the standard definitions of the eligible population, including elements such as age.

NUMERATOR SPECIFICATIONS

For the measures included in this report, the numerator is the number of patients identified from the eligible population who meet the numerator criteria. The numerator is calculated using the clinical quality data submitted by the medical group; this data is verified through MNCM's validation process.

CALCULATING RATES

Due to the dynamic nature of patient populations, rates and 95 percent confidence intervals are calculated for each measure for each medical group/clinic regardless of whether the full population or a sample is submitted. The statewide average rate is displayed when comparing a single medical group/clinic to the performance of all medical groups/clinics to provide context. The statewide average is calculated using all data submitted to MNCM which may include some data from clinics located in neighboring states.

THRESHOLD FOR PUBLIC REPORTING

MNCM has established minimum thresholds for public reporting of clinical data submission measures to ensure statistically reliable rates. Only medical groups and clinics that meet the threshold of 30 patients in the denominator of each measure are publicly reported.

RACE, HISPANIC ETHNICITY, LANGUAGE, AND COUNTRY OF ORIGIN ANALYSES

For the quality measures, the RELC data is submitted by medical groups through MNCM's clinical data submission process. Please refer to the MNCM [*Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups*](#) for more information about this data.

BEST PRACTICES FOR CLINICAL QUALITY MEASURES

Race, Hispanic ethnicity, preferred language, and country of origin data collection undergoes a unique validation process to ensure that medical groups collect these data elements from patients using best practices. Best practices are defined as:

1. Patients self-report their race and Hispanic ethnicity.
2. Patients have the option to select one or more categories for race (i.e., medical groups/clinics do not collect data using a multi-racial category).
3. Medical groups/clinics have the ability to capture and report more than one race as reported by the patient.

A medical group/clinic must meet all the criteria for each data element to achieve best practice status and to have their data included in the rate calculation. Only validated data collected using best practices are used to calculate rates by race, Hispanic ethnicity, preferred language, and country of origin.

LABELING CHANGES

Certain race/ethnicity categories have undergone labeling changes for this report to be consistent with more updated and appropriate terminology. Below is a table describing how the category was submitted to MNCM and its corresponding label change:

Submitted Label	Updated Label
American Indian or Alaska Native	Indigenous/Native
Black or African American	Black
Hispanic or Latino	Hispanic/Latinx
Not Hispanic or Latino	Not Hispanic/Latinx